OSU Veterinary Medical Hospital
Cardiology Patient History

TO BE COMPLETED BY OWNER TO THE BEST OF YOUR KNOWLEDGE

Reason for First Visit:

1.) Is your animal on heartworm preventative? (circle) No Yes If yes, how long? __________________________

2.) When was your pet last heartworm tested? ______________________________________________________

3.) Has your pet been coughing? (circle) No Yes If yes, how often and for what duration? (i.e., once a day for 5 minutes) ____________________________

4.) Fainting or collapsing? (circle) No Yes If yes, how often and for what duration? __________________________

5.) Abnormal or difficulty breathing? (circle) No Yes If yes, how long? ____________________________

6.) Other respiratory signs (sneezing, noise, discharge)? No Yes If yes, please list: ____________________________

7.) Ability to exercise? (circle) Normal Reduced

8.) List type of daily exercise, level and frequency: ______________________________________________________

9.) Drinking (circle) Normal Abnormal 10.) Urinary Output (circle) Normal Abnormal

11.) Primary Diet – list brand, amount and frequency: ______________________________________________________

List # of treats/day: ____________________________

12.) Weight loss? (circle) No Yes If yes, how many pounds and over what period of time? __________________

13.) Medications? List name, strength and dosage: ______________________________________________________

14.) Any bloodwork within the last 6 months? (circle) No Yes If yes, list the type and when: __________________

15.) Any chest x-rays within the last month? (circle) No Yes If yes, when? ____________________________

16.) Has your pet ever experienced a reaction to any treatment or medication? (circle) No Yes If yes, please explain: ____________________________
17.) Where does your pet primarily stay? (circle) **Indoors**  **Outdoors**

18.) Has your pet ever traveled out of state? (circle) **No**  **Yes**  If yes, list when and where: ________________________________

19.) When were your pet’s last vaccinations given? ________________________________________________________________

**Recheck Exam:**

1.) How is your pet doing at home? ________________________________________________________________

2.) Any new symptoms (please list)? ________________________________________________________________

3.) Have you been to your family veterinarian for cardiac problems recently? (circle) **No**  **Yes**

4.) If you answered yes to question 3, were any tests performed (please list)? ____________________________

5.) Please list all current medications: ________________________________________________________________

6. Do you need any refills today? (circle) **No**  **Yes**  If yes, please circle above or list meds: ________________

__________________________________________________________________________________________