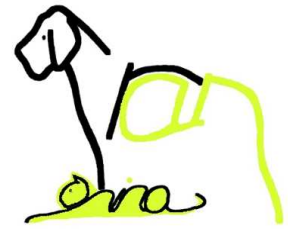


MEDICAL HISTORY



Date: _____

Owner:

Name: _____

Address: _____

Phone: _____

E-Mail: _____

Animal:

Name: _____ Age: _____

Sex: _____ Breed: _____

Since when do you own the animal: _____

General behaviour: _____ Weight: _____ kg

Food / Water intake: _____

Defecation / urination: _____

Previous diets: _____

Vaccinations: _____

Flea / tick prevention: yes _____ no

Deworming: yes _____ no

Visiting of foreign countries: yes _____ no

Are other animals / people affected (itching, rash ...)?
yes _____ no

Are other animals living in the same household? yes _____ no

Age at first onset of the disease: _____

Seasonal occurrence: yes _____ no

Description of the symptoms:

Pretreatments and diagnostic tests:

