



Marketplace
Veterinary
Clinic

Marketplace Veterinary Clinic

3116 Horizon Drive – Suite 1
Bryant, AR 72022
501-943-8055
marketplacevet@outlook.com

PATIENT HISTORY CHECK-IN FORM

Client Name: _____

Patient Name: _____

Species/Breed: _____

Age: _____ Sex: _____ Weight: _____

If female and not spayed when was the last heat cycle? _____

Primary Concern Today:

Onset of Problem: _____

Sudden Gradual Worsening Improving Unchanged

Daily Diet:

Primary Food (brand/type): _____

Supplements: _____

Treats/Table Food: _____

Appetite & Diet

Food Consumption: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Increased <input type="checkbox"/> Not Eating		Other pets share water source? <input type="checkbox"/> Yes <input type="checkbox"/> No
Defecation <input type="checkbox"/> Normal <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Straining	Urination <input type="checkbox"/> Normal frequency <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Accidents in house	Feeding Method: <input type="checkbox"/> Free choice <input type="checkbox"/> Scheduled meals Quantity fed in one day: _____

<input type="checkbox"/> Blood <input type="checkbox"/> Mucus Stool description:	<input type="checkbox"/> Straining <input type="checkbox"/> Dribbling <input type="checkbox"/> Blood noted Notes	Water Intake <input type="checkbox"/> Normal <input type="checkbox"/> Increased (approx. how much more?): _____ <input type="checkbox"/> Decreased
--	---	--

General Health

Weight: <input type="checkbox"/> Stable <input type="checkbox"/> Loss <input type="checkbox"/> Gain	Activity Level: <input type="checkbox"/> Normal <input type="checkbox"/> Lethargic <input type="checkbox"/> Restless
Vision: <input type="checkbox"/> Normal <input type="checkbox"/> Change Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Change	Coughing: <input type="checkbox"/> No <input type="checkbox"/> Yes
Vomiting: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: Frequency: _____ Relation to eating: _____ Appearance: _____ Medications (include dose & frequency): Any unusual discharge or odor? _____ Other concerns: _____	

DERMATOLOGY (Skin / Ears)

Hair loss: <input type="checkbox"/> No <input type="checkbox"/> Yes (location): _____	Itching: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Continuous <input type="checkbox"/> Seasonal (when?): _____
Other pets affected? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fleas seen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Odor from skin/ears?

Current flea prevention: _____	_____
Pigment or texture changes of the skin and hair? _____	Dandruff? <input type="checkbox"/> No <input type="checkbox"/> Yes (where?): _____
Bathing frequency: _____	Last bath/product used: _____
Previous treatments & response (please list time frames symptoms occurred, if there were any medications given to help the symptoms, and what level of response was noted): _____	

OPHTHALMOLOGY (Eyes)

Vision changes? <input type="checkbox"/> No <input type="checkbox"/> Yes Color change in eye? _____	Discharge? <input type="checkbox"/> None <input type="checkbox"/> Clear <input type="checkbox"/> Mucoïd <input type="checkbox"/> Yellow/Green <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Redness? <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling? <input type="checkbox"/> Yes <input type="checkbox"/> No	Signs of pain: <input type="checkbox"/> Squinting <input type="checkbox"/> Pawing/rubbing <input type="checkbox"/> Light sensitivity

GASTROINTESTINAL

Exposure to: <input type="checkbox"/> Toxins/plants <input type="checkbox"/> Trash	Does pet eat stool? <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccines current? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

<input type="checkbox"/> New food <input type="checkbox"/> Toys/foreign objects	Do you watch your pet eat? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea details (frequency/texture/blood present/amount?): _____	
Constipation details (how long has this persisted): _____	
Vomiting details (frequency/color/after meals?): _____	

MUSCULOSKELETAL

Lameness? <input type="checkbox"/> No <input type="checkbox"/> Yes Which leg(s): _____	Is this a reoccurring issue? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give brief history: _____	
Known trauma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	Difficulty: <input type="checkbox"/> Rising <input type="checkbox"/> Stairs <input type="checkbox"/> Jumping	Ticks seen? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last time a tick was pulled off the animal: _____
Is the animal free roaming or otherwise unsupervised? <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight bearing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscle loss/swelling noted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____		

URINARY

Change in urination frequency? _____		Straining? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine? <input type="checkbox"/> No <input type="checkbox"/> Before urinating <input type="checkbox"/> During <input type="checkbox"/> After	Quantity produced: <input type="checkbox"/> Normal <input type="checkbox"/> Small amounts <input type="checkbox"/> Large amounts	Urinating while: <input type="checkbox"/> Awake <input type="checkbox"/> Asleep
Change in water consumption? <input type="checkbox"/> more <input type="checkbox"/> less		