PINE TREE
VETERINARY HOSPITAL

Dog/Cat Information

Owner's Last Name:_____ First:_____
Patient's Name: _____ Age/Birthday: _____

Species: Cat ❑ Dog ❑ Breed:_____ Color:_____

Sex: Male ❑ Female ❑ Spayed/neutered? Yes ❑ No ❑ Microchipped? Yes ❑ No ❑

Does your pet have allergies? Yes ❑ No ❑ Not sure ❑

If yes, please list them_____
Is your pet primarily outdoors or indoors?_____

Has your pet ever had a reaction to vaccines or medications? Yes ❑ No ❑

If yes, what was the reaction related to?_____
Is your pet on any flea or tick prevention? _____
List any major surgeries your pet has had:

_____
List any behavior problems we need to be aware of:

_____
List all foods and treats you give your pet:

_____
List any medications or supplements given:

_____

Previous Medical Records? Yes ❑ No ❑

If yes, which clinic?_____ May we contact them? Yes ❑ No ❑

Please circle any of the following medical issues you have concerns with for your pet:

Vomiting	Unusual Odors	Increased urination	Lethargy
Diarrhea	Limping/Stiffness	Increased Drinking	Inappetance
Coughing	Scratching at ears	Inappropriate Urination	Hair Loss

Other: _____

This form can be faxed to us at (425) 947- 9832
or scanned and emailed to pinetreehospital@gmail.com
or brought in with you for your first appointment

Professional Fees are to be paid at time of services. For your convenience we accept Cash, Check (with a valid driver's license), Visa, Mastercard, Discover, American Express, and care credit. Returned checks are subject to a $35.00 fee.

Signature_____**Date**_____