



**New Pet Information Form**

|   |   |           |           |
|---|---|-----------|-----------|
| <b>Please complete information for all your pets - Thank You!</b> | Pet<br>#1   | Pet<br>#2 | Pet<br>#3 |
| Diet (Name of Your Pet's Food)                                    |   |           |           |
| Daily Medications, Vitamins or Treats                             |   |           |           |
| Shampoo/Flea Products Used  |   |           |           |
| Hours Spent Outside Each Day                                      |   |           |           |
| <b>Vaccinations</b>   | Please note the dates the following vaccines/tests were given |           |           |
|   | Pet #1  | Pet #2    | Pet #3    |
| <b>DOGS:</b>  |   |           |           |
| <b>DA2LPP</b><br>(Distemper/Parvo )                               |   |           |           |
| <b>Bordetella</b> (Kennel Cough)                                  |   |           |           |
| <b>Corona</b> (Dogs)  |   |           |           |
| <b>Other Vaccines</b> - Please Specify                            |   |           |           |
| <b>Rabies 1 year or 3 year</b>                                    |   |           |           |
| <b>CATS:</b>  |   |           |           |
| <b>FVRCP</b> (Infectious Diseases)                                |   |           |           |
| <b>FELV</b> (Feline Leukemia)                                     |   |           |           |
| <b>FIP</b> (Feline Infectious Peritonitis)                        |   |           |           |
| <b>Rabies 1 year or 3 year</b>                                    |   |           |           |
| <b>Other Vaccines</b> - Please Specify                            |   |           |           |
| <b>Heartworm Test</b> (Dogs)                                      |   |           |           |
| FELV Test or FIV Test ? (Cats)                                    |   |           |           |
| <b>Fecal Test</b> (Stool Exam for Worms)                          |   |           |           |

|   |  |  |  |
|---|--|--|--|
| <b>Dentistry</b> (Approx Date Work was Done)    |  |  |  |
| <b>Geriatric Health Screen</b><br>(Approximate) |  |  |  |
| <b>Medical History - Prior Illness/Surgery:</b> |  |  |  |
|   |  |  |  |
|   |  |  |  |
| <i>Thank You!</i>                               |  |  |  |

**NOTE: Be sure to ask us about our VIP Wellness Program.**

**If Military: Rank & Unit:** \_\_\_\_\_ **P.C.S.** \_\_\_\_\_ **E.T.S.**  
 \_\_\_\_\_

**Spouse's/Other's Employer Name & Address:**  
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