The Center of Veterinary Expertise
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Dentistry Medical History Form

Date: _____

Patient Name: _____ **Client's Name:** _____

Please list any previous surgeries and/or dental procedures your pet has had:

_____

_____

_____

If your pet has taken any medications, supplements or over the counter meds within the last 3 months, please list them below.

Name	Strength	Dose	Frequency
Name	Strength	Dose	Frequency
Name	Strength	Dose	Frequency
Name	Strength	Dose	Frequency

Please review the list below and mark any of the boxes that apply to your pet.

- ☐ Abnormal Bloodwork Results
- ☐ Anesthesia Related Regurgitation
- ☐ Any Change in Eating Habits
- ☐ Bleeding Disorders
- ☐ Collapsing Trachea
- ☐ Coughing
- ☐ Diabetes
- ☐ Dietary Restrictions
- ☐ FIV (cats Only)
- ☐ Heart Murmur/Heart Disease
- ☐ IBD (Irritable Bowel Disease)
- ☐ Indoors Only
- ☐ Indoor/Outdoor
- ☐ Kidney Disease
- ☐ Neck or Back Pain
- ☐ Recent Weight Loss
- ☐ Seizures
- ☐ Sneezing