



Phone: (916) 683-4000  
Fax: (916) 683-4040

## CANINE DISEASE/RISK ASSESSMENT

Owner's Name (Last, First): \_\_\_\_\_

Dog's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Primary Breed: \_\_\_\_\_ Color: \_\_\_\_\_

Sex:  Male  Female  Spayed  Neutered

Birthday or Age: \_\_\_\_\_ How long have you had this dog? \_\_\_\_\_

This dog is from:  Rescue  Breeder  Stray  Store  Other \_\_\_\_\_

Previous veterinarian: \_\_\_\_\_

## GENERAL HEALTH

What food are you feeding your dog? \_\_\_\_\_  
How much? \_\_\_\_\_ for how long? \_\_\_\_\_

Do you feed your dog treats?  Yes  No  
If yes, how often: \_\_\_\_\_

Currently taking medications or other supplements?  Yes  No  
If yes, please list the medications and dosage. \_\_\_\_\_  
\_\_\_\_\_

Do you take your dog to a boarding kennel, a groomer, dog shows, or a dog park?  
 Yes  No

Any significant changes in your dog's weight?  Yes  No

Any changes in:  thirst  appetite  urination  defecation  
Please describe: \_\_\_\_\_

Chronic or recurring:  vomiting  diarrhea  coughing  sneezing  
Please describe: \_\_\_\_\_

## RISK ASSESSMENT

- 🐾 Your dog is kept:  completely outdoors  mostly outdoors  completely indoors  
 mostly indoors  half indoor/half outdoor
  
- 🐾 Exposure to other dogs:  none  very little  some interaction  a lot of friendly interaction  gets in fights
  
- 🐾 Currently on heartworm medication?  Yes  No Which brand? \_\_\_\_\_
  
- 🐾 Currently on flea medication?  Yes  No Which brand? \_\_\_\_\_
  
- 🐾 Ever seen a tick on any of your pets?  Yes  No If yes, how long ago? \_\_\_\_\_
  
- 🐾 Ever had a vaccine reaction?  vomiting  trouble breathing  swollen muzzle or around eyes  hives  lumps that didn't go away  hair loss at injection site  none
  
- 🐾 Does your dog have a microchip?  Yes  No

Anything else you would like us to know about your dog? (previous surgeries, urination problems, trouble moving, etc.) \_\_\_\_\_  
\_\_\_\_\_

Vaccination			Date and Name of Clinic (if known)
Rabies	<input type="radio"/> Yes	<input type="radio"/> No	_____
Distemper (DH2PP)	<input type="radio"/> Yes	<input type="radio"/> No	_____
Parvovirus	<input type="radio"/> Yes	<input type="radio"/> No	_____
Bordetella	<input type="radio"/> Yes	<input type="radio"/> No	_____

Date: \_\_\_\_\_

\_\_\_\_\_

*Owner Signature*