care center

Your trusted partner in specialized veterinary care.

INTERNAL MEDICINE DEPARTMENT VOMITING HISTORY FORM

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6405 Clyo Rd. • Centerville, OH 45459 • **P**: 937.428.0911 • **F**: 937.428.6667
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How long has your pet been vomiting? _____

How frequently is your pet vomiting? (daily, weekly, 2x/week, etc.) _____

What does your pet vomit? ☐ Phlegm ☐ Bile ☐ Blood-tinged food (undigested or digested)

When they vomit, is there an abdominal component?
☐ Yes ☐ No (does it just come out or do they actually heave with abdomen)

Does your pet vomit immediately after meals? ☐ Yes ☐ No

Do they vomit at random times or always the same time of day? _____

What type of food does your pet eat? Please include any treats given, including human food:

_____

Has your pet had any recent diet changes? ☐ Yes ☐ No

Does your pet get into things, i.e. chew up toys, eat string, get into garbage? ☐ Yes ☐ No

If Yes, what have they gotten into and when? _____

When did your pet eat last? _____

Has your pet had any change in appetite? ☐ Increased ☐ Decreased ☐ No Change

Has your pet lost any weight? ☐ Yes ☐ No

If Yes, what was their weight before any illness started? _____

Does your pet have any diarrhea? ☐ Yes* ☐ No *If Yes, please fill out diarrhea form also.

If your pet is a cat, are they indoor only? ☐ Yes ☐ No

Are there any other cats in the house? ☐ Yes ☐ No

Has your cat been tested for feline leukemia or FIV? ☐ Yes ☐ No

Are any other pets in the house sick? ☐ Yes ☐ No

If Yes, please describe: _____

_____

Is your pet current on vaccines? ☐ Yes ☐ No

Please list any medications your pet is currently taking, including heartworm preventative and topical medications:

MEDICATION	**DOSAGE**	**TIME LAST ADMINISTERED**