

**Pet's Name:**

Breed:

Age:

Owner's Name (First, Last):

Owner's Home Phone:

Owner's E-mail address:

Fax to: (201) 262-4275

or e-mail to: [diethistory@oradell.com](mailto:diethistory@oradell.com)

Once received, you will be contacted to schedule an appointment.

**Oradell Animal Hospital Nutrition History Form**

DATE: \_\_\_\_\_

Current body weight: \_\_\_\_\_ Usual body weight: \_\_\_\_\_

Do you consider your pet: Overweight \_\_\_\_\_ Underweight \_\_\_\_\_ Ideal \_\_\_\_\_

Reason for Nutrition Consultation (note: **We do not formulate raw diets**)

List all veterinary hospitals and names of veterinarians who have cared for your pet in the past 12 months: \_\_\_\_\_

Please send **ALL** physical exam forms, diagnostic test results (lab work, ultrasound/radiography reports, biopsy reports, bladder stone analysis, etc.) from **EVERY** veterinarian your pet has seen in the past 12 months (longer for more chronic conditions) to Oradell Animal Hospital. Once medical records and diet history form are received, you will be contacted by the nutrition technician to schedule an appointment.

Please list all food(s) you currently feed at mealtime. Include **ALL** commercial pet foods. If you add human food items to a commercial food, please list that as well. If you cook for your pet provide the detailed recipe (for example "4 ounces of 85% lean ground beef pan-fried & 1 cup of cooked long-grain brown rice daily") **The description should provide enough detail that the reader could purchase the same food or prepare the exact recipe.**

**Meals:****Amount Fed**

Brand/Product/Food	Form	Per Meal	# of Meals	Flavor	Fed Since
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**EXAMPLES:**

Purina Dog Chow Healthy Morsels	dry	1 1/2 cups	twice a day	chicken and rice	May 2013
Boneless Chicken (white meat)	boiled	2 ounces	three times a week		June 2015

List all treats & "between meal snacks" include biscuits, pet treats, rawhides, pig's ears, table foods etc. Anything given as a "snack" or "treat"

Brand/Product/Treat	Size	Flavor	Quantity Per Day	Fed Since
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**EXAMPLES:**

Greenies	small	regular	twice per week	April 2012
Milk Bones	medium	beef	three per day	June 2013
Kraft Non-fat American Cheese	slice	--	two per day	May 2015

Please describe pet's activity level (i.e. type, duration &amp; frequency): \_\_\_\_\_

Do you have other pets? ☐ Yes ☐ No If so, please list (species, age): \_\_\_\_\_Do you have children in the home? ☐ Yes ☐ NoIs your pet fed in the presence of other animals? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

Does your pet have access to other unmonitored food sources (i.e. food from a neighbor, scavenging from the yard/trash, hunting outdoors, etc.)? ☐ Yes ☐ No If yes, please describe: \_\_\_\_\_

Who typically feeds your pet? \_\_\_\_\_  
How do you store your pet's food? \_\_\_\_\_

Do you use food to administer medication? If yes please describe type of food and amount: \_\_\_\_\_  
\_\_\_\_\_

Please describe anything you give your pet for dental health (treats, dental chews, bones or similar products):  
\_\_\_\_\_

If you brush your pet's teeth, please list the toothpaste you use (if any): \_\_\_\_\_

**Please list other foods your pet has received in the past but is NOT currently eating, indicating the approximate time period when they were fed. *Examples are given in italics.***

Brand/Product/Food	Form	From	To	Reason Stopped
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**EXAMPLE:**

Hill's Science Diet Feline Growth	can	June 2006	March 2007	became an adult
Purina Veterinary Diets OM	dry	July 2011	October 2015	became itchy

Please list the name of each additional nutritional supplement your pet receives, indicate how much and how often your pet receives it (i.e. herbal product, fatty acid, vitamin or mineral supplement): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your pet's current and past medical problems, if any, date/year diagnosed, and whether they have been resolved or not:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all the medications your pet is currently receiving and any administered over the past three months (indicate medications that are current and doses/strengths and frequency): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check the box, and indicate frequency, if the following problems have been experienced by your pet prior to today's visit:

- ☐ Recent involuntary or unintended ☐ weight gain **OR** ☐ weight loss  
☐ How many pounds? \_\_\_\_\_ Over what time period: \_\_\_\_\_  
☐ Vomiting \_\_\_\_\_ times/day \_\_\_\_\_ times/week  
☐ Diarrhea \_\_\_\_\_ times/day \_\_\_\_\_ times/week

Have you observed changes in any of the following:

- ☐ Urination **OR** ☐ Drinking What was the specific change? \_\_\_\_\_  
Since when? \_\_\_\_\_  
☐ Defecation What was the specific change? \_\_\_\_\_  
Since when? \_\_\_\_\_  
☐ Appetite What was the specific change? \_\_\_\_\_  
Since when? \_\_\_\_\_

Does your pet have? ☐ allergies **OR** difficulty ☐ chewing ☐ swallowing

If so, please describe: \_\_\_\_\_

Any other information you feel is relevant: \_\_\_\_\_

\_\_\_\_\_