Chicago Equine Medical Center
26996 North Darrell Road, Wauconda, IL 60084
www.chicagoequine.com 847-526-9550

New Patient History Form

Client: _____

Horse: _____

Stable/Farm where boarded_____

Age: _____ Breed: _____Gender_____Date of Last Coggins_____

Insurance Company: _____Phone number_____

Referring Vet: _____Phone number_____

Would you like updates sent to your referring Vet? yes____ no____

Last vaccination date: _____.

Vaccinated with (check all that apply) EWT___ West Nile___ Flu and Rhino ___ Flu only___ Rhino only__

Potomac Horse Fever___ Strangles____ Rabies ____

Deworming History: _____

Use: _____

Number of times ridden per week/intensity of work: _____

Current Medications/Supplements: _____

Presenting Complaint *(reason for visit)*: _____

_____

Are there any pertinent radiographic, ultrasonographic or thermographic findings?

_____

Have any treatments been pursued *(corrective shoeing, intra-articular joint therapy, shockwave therapy, etc.)*?

_____

_____

Is there a history of trauma or surgery? *(If yes, please explain)*_____

_____

Additional questions/concerns/observations you have: _____

_____

_____