MEDICAL HISTORY cont'd

Please check applicable boxes and provide details if necessary:

- ❑ High/Low blood pressure
- ❑ Heart disease
- ❑ Hemophilia
- ❑ Migraines
- ❑ Dizziness/Fainting/Blackouts
- ❑ Allergies & likely reactions
- ❑ Epilepsy
- ❑ Cancer
- ❑ Asthma
- ❑ Muscular weakness
- ❑ Rheumatic fever
- ❑ Impaired hearing
- ❑ Impaired sight
- ❑ Memory loss
- ❑ Reduced stamina
- ❑ Chronic pain
- ❑ Brittle bones
- ❑ Diabetes
- ❑ Convulsive seizures
- ❑ Coordination problems
- ❑ Stroke
- ❑ Hernia
- ❑ Polio
- ❑ Spasticity
- ❑ Depression
- ❑ Imbalance
- ❑ Infantile paralysis
- ❑ Nervous disorders
- ❑ Limited mobility
- ❑ Skin sensitivity
- ❑ Speech impediment

Details:

_____

_____

_____

Is there any other information, you feel is pertinent, that may affect the applicant's ability to care for a companion dog?

_____

_____

_____

_____

_____

Physician Name: _____ Date: _____

(Please print name)

Physician Address: _____

Physician Signature: _____ Phone #: _____

***NOTE: PLEASE RETAIN A COPY OF THIS COMPLETED FORM FOR YOUR FILES**