Feline History Questionnaire

Date: _____

Patient: _____ Client: _____

Do you use Care Credit/ScratchPay? Y ___ N ___ Do you want information on financing options? Y __ N ___

Do you want information on cutting cost with pet insurance? Y _____ N _____

Sex: M _____ F _____ Spayed/Neuter: Y _____ N _____ Interested in Spaying/Neutering? Y _____ N _____

Microchip# _____ Interested in Microchipping Y _____ N _____

FELV / FIV tested? Y _____ N _____ Interested in Testing Y _____ N _____

Age: _____ Weight: _____

Nails Long? Y _____ N _____ Nail Trim today? Y _____ N _____

Are there other pets in the household? Y _____ N _____ Canine: _____ Feline: _____ Other: _____

Reasons for today's visit? _____

Ongoing problems? _____

Current:

Medications/Supplements: _____

Any allergies to any medications or vaccines? Y _____ N _____ What and when? _____

Diet:

Brand: _____ Canned? Y _____ N _____ Dry? Y _____ No _____

How much do you feed? _____ How often do you feed? _____

Recent dietary changes? _____

What kind of treats / snacks / table scraps / chews do you give your pet? _____

When is the last time your pet ate? _____

Parasite Prevention:

What Heartworm Preventative do you give your pet? _____

What day of the month do you give your pet's Heartworm Preventative? _____ Every month? Y _____ N _____

What Flea and Tick Preventative do you give your pet? _____

Interested in Heartworm or Flea and Tick Preventative today? Y _____ N _____

Lifestyle:

Indoor only_____ Indoor / Outdoor_____ Outdoor Only_____ Hunts_____ Boards_____ Groomed_____ Travel_____

Feline Wellness History Questionnaire

Urine:

Normal _____ Increased _____ Decreased _____ Blood Present _____

Comments: _____

Bowel Movements:

Normal _____ Increased _____ Decreased _____ Diarrhea _____ Constipation _____ Blood Present ____

Comments: _____

Dental Status:

Bad Breath _____ Sore Gums _____ Problems Chewing _____ Drooling _____ Decreased Appetite _____

What Dental care do you provide for your pet at home? _____

Mobility / Activity:

Normal _____ Unable to jump _____ Limping _____ Sore _____ Painful _____ Arthritic _____

Hair / Coat:

Clean and Shiny _____ Dull _____ Dandruff _____ Hair Loss _____ Mats _____ Decreased Grooming _____

Are any Fleas present? Y _____ N _____ Are any Ticks present? Y_____ N _____

Any bumps or masses that the Doctors hould be aware of? Y _____ N _____

If yes, where and when was it seen, and changes? _____

Does your pet have any of these symptoms?

Coughing _____ Vomiting _____ Diarrhea _____ Sneezing _____ Hairballs _____

Has your pet been seen elsewhere for medical care since we last saw him / her? Y _____ N _____

If so, when? _____ Clinics name: _____