

PET NAME: _____ **OWNER NAME:** _____

WHY IS YOUR PET COMING TO SEE US: *(presenting complaint)* _____

SYMPTOMS: *(Elaborate and include duration as needed)*

Appetite: Normal Decreased Increased _____

Thirst: Normal Decreased Increased _____

Stools: Normal Abnormal Increased _____

(If abnormal, please describe color and consistency. Any blood, mucus, straining, increased frequency or increased urgency to defecate) _____

Urinations: Normal Abnormal *(If abnormal, please describe color, any blood, and straining, leaking, accidents in the house, increased frequency or urgency to urinate)* _____

Vomiting? Yes No *(If yes, please describe what the vomit looks like and how often your pet is vomiting)* _____

Coughing/Hacking Cough? Yes No *(If yes, please describe how often, if coughing is worse at any certain time of the day and if the cough is worsened by exercise or excitement)* _____

Fainting/Collapse? Yes No *(If yes, please describe how frequently this has occurred, how long the episodes last, what happened right before the episode and how long does it take for your pet to return to "normal")* _____

Labored Breathing? Yes No (If yes, please describe when this occurred, was any medication given or prescribed to help improve the breathing? _____)

Activity level: Normal Decreased Increased
(Please describe when you first noticed a change in your pet's activity level) _____

Please describe any other symptoms not listed above: _____

Have any of the following diagnostic tests been performed?

Blood Work: Yes No If yes, when? _____
EKG (electrocardiogram): Yes No If yes, when? _____
Radiographs (X-Rays): Yes No If yes, when? _____
Echocardiogram (cardiac ultrasound): Yes No If yes, when? _____

PRIOR MEDICAL HISTORY:

Does your pet have any current/past medical problems, prior surgeries (other than spay/neuter) or a prior need for hospitalization?

1. _____
2. _____
3. _____

Is your pet up-to-date on his/her rabies vaccination? Yes No

CATS:

Has your cat been tested for: FeLV (Feline Leukemia Virus) Yes No Unsure
If yes, when: _____

FIV (Feline Immunodeficiency Virus) Yes No Unsure
If yes, when: _____

Is your cat: Indoor Only Indoor/Outdoor Outdoor Only

MEDICATIONS:

List all medications given to your pet including:

Heartworm preventative: _____

Last given: _____

Flea/tick preventative: _____

Last given: _____

Vitamins/other supplements: _____

Last given: _____

Please list all medications given to your pet, ie: name/dose/frequency (please list dose in milligrams if known):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Do you feel that any of these medications have helped any of your pet's symptoms? Yes No

(If yes, please explain which ones helped and how) _____

Please include any important information not covered on this questionnaire you would like the doctor to know:

