

DROP - OFF PRE-EXAM QUESTIONNAIRE

OWNER: _____ PATIENT: _____ DATE: __/__/__

HAVE YOU MOVED IN THE LAST 6 MONTHS!!!! YES NO

The Doctors *REALLY* need this information so LET THE QUESTIONS BEGIN !!.....☺

Number of cats in the household? _____

Indoor Outdoor Both

Free roam Leash Supervised Other: _____

DIET: Dry Brand: _____ Wet Brand: _____ Treats? _____
Amount: _____/day Amount: _____/Day Type: _____

What medications are you currently giving to your cat? _____

When was the medication last administered? Time: ____:____ AM PM

Flea control used? Brand? _____ Last date applied? __/__/__

ATTITUDE? Normal Quiet Withdrawn Depressed Irritated Anxious Lethargic
 Other: _____ How long? _____

APPETITE? Normal Increased Decreased Not eating Unsure How long? _____
WATER CONSUMPTION? Normal Increased Decreased Not drinking Unsure How long? _____

SNEEZING? Yes No Unsure How long? _____ COUGHING? Yes No Unsure How long? _____

EYE DISCHARGE? Yes No How long? _____ NASAL DISCHARGE? Yes No How long? _____

EYE DISCHARGE DESCRIPTION ▶ Which side(s) _____ Watery Thick mucus Green Brown Blood

NASAL DISCHARGE DESCRIPTION ▶ Which side(s) _____ Watery Thick mucus Green Brown Blood

VOMITING? Yes No Unsure When did it start and describe how often the vomiting is occurring. Please describe how it looks too. _____

DIARRHEA? Yes No Unsure When did it start and describe how often the diarrhea is occurring. Please describe how it looks too. _____

DESCRIPTION OF THE DIARRHEA? Blood Mucous Hair Grass Plants Dark Colored Watery
 Soft but formed Soft but not formed(cow pie!)

STRAINING TO DEFECATE? Yes No Unsure How long? _____

HARD STOOLS? Yes No Unsure How long? _____

CHANGE IN URINE VOLUME? No More than usual Less than usual Unsure How long? _____

How often? _____ How much? _____

STRAINING TO URINATE? Yes No Unsure How long? _____ How often? _____ How much? _____

FREQUENT TRIPS TO THE LITTER BOX? Yes No Unsure How often? _____ How much? _____

USING LITTER BOX? Yes No Urinating outside box? How long? _____ Defecating outside box? How long? _____

LITTER BOX INFORMATION? Brand? _____ Clay Clumping Scented Unscented

How long used? _____ Number of litter boxes? _____ Location of litter boxes? _____ Are liners used? Yes No

Are the Litter boxes covered? Yes No How often are litter boxes scooped? _____ Changed completely? _____

STRESS OR CHANGES? Moved New pet New member in household Guests visiting Holidays New work

Schedule Owner gone more

ANY OTHER CHANGES NOTICED? _____

OTHER SERVICES REQUESTED TODAY? _____

ADDITIONAL QUESTIONS/CONCERNS TO BE ADDRESSED TODAY? _____

THANKS FOR TAKING THE TIME TO TRY AND MAKE MY LIFE AS GOOD AS POSSIBLE,

YOUR LOVING FELINE FRIEND,