NEW FELINE PATIENT HISTORY QUESTIONNAIRE

Thank you for taking the time to fill out before your appointment.
Feel free to fax/ scan & email before your appointment or print and bring with you.
FAX: 804-794-4867
Sycamorevet@comcast.net

Your Name : Patient Name: Date:

1. Medications– It is helpful if you list name and strength of medication:

Heartworm Prevention: Flea/Tick Control: Year round?

Other (this includes vitamins, and supplements):

2. What is your pet's primary diet?
Dry or Canned?
Free Feed Y/N
Meal Feed Y/N if yes how often _____times per day
Treats?

3. Other pets in household? Y/N Please list Breed and Ages

3. What percentage of time do you estimate your pet spends outdoors? % Supervised Y/N

4. Does your cat interact with other cats outside or get into fights with other cats? Y/N

5. Any injury or illness in the past No____ Yes_____

6. Any history of seizures? No ___ Yes (frequency)_____

7. Has your pet had any allergic reactions to any vaccines or medications: No Yes (list)

8. Any recent changes such as increase or decrease in?
Appetite
Water Intake
Weight
Urine or Stool output

Does your cat use a litter box? Y/N
If yes any litter box issues?

9. Any issues with?
Lameness If so which leg?
Ear infections
Skin/Scratching
Vomiting
Diarrhea
Urinary Issues