☐Confirmed Client Phone Number, Address & E-mail Date_____

Feline Wellness History Questionnaire

Patient: _____Client: _____

Sex: ☐ M ☐ F Altered? ☐ Y ☐ N Microchipped? ☐ Y ☐ N FeLV/FIV tested? ☐ Y ☐ N When? _____

Age _____ Weight _____ Body Condition Score ___/9 Temperature _____ Pulse ____ Respiration _____

Mucous Membrane Color: ☐ Pink ☐ Pale ☐ Icteric Capillary Refill Time _____ seconds

Reason for today's visit: _____

Is there anything you want to discuss with the doctor today? _____

Ongoing problems: _____

Current medications/supplements: _____

Which type of medications are you able to give your cat? ☐ Pills ☐ Liquids ☐ Injections

Diet: Canned _____ Dry _____

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

What kinds of treats / snacks / table scraps / chews do you give your cat? _____

Parasite Prevention: What heartworm preventative do you give your cat? _____

What day of the month do you give your cat's heartworm preventative? _____ Every month? ☐ Y ☐ N

What flea/tick preventative do you give your cat? _____ How often? _____

Lifestyle: ☐ Indoor Only ☐ Indoor/Outdoor ☐ Outdoor Only ☐ Hunts ☐ Fights ☐ Groomer ☐ Travel

Urine: ☐ Normal ☐ Increased ☐ Decreased ☐ Painful ☐ Bloody ☐ Straining Excessive drinking? ☐ Y ☐ N

Comments _____

Bowel Movements: ☐ Normal ☐ Increased ☐ Decreased ☐ Diarrhea ☐ Constipation

Comments _____

Dental Status: ☐ Bad breath ☐ Sore gums ☐ Problems chewing ☐ Drooling ☐ Decreased appetite

Dental Grade: ☐ 1 ☐ 2 ☐ 3 ☐ 4

What dental care do you provide for your cat at home?

☐ Drinking water additive ☐ Dental diet ☐ Dental chews ☐ Oral rinse/gel ☐ Brush teeth

Mobility/Activity: ☐ Normal ☐ Unable to jump ☐ Limping ☐ Sore ☐ Painful ☐ Arthritic

Behavior Concerns: ☐ Vocalizing ☐ Aggression ☐ Biting ☐ Scratching ☐ House soiling ☐ Excess licking

Hair/Coat: ☐ Clean/Shiny ☐ Dull ☐ Dandruff ☐ Hair loss ☐ Mats ☐ Decreased grooming

Are there fleas present? ☐ Y ☐ N Are there ticks present? ☐ Y ☐ N

Any bumps or skin masses that the doctor should be aware of? ☐ Y ☐ N

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

Does your cat have any of these symptoms? How long has it been going on? How frequent? Describe.

☐ Coughing: _____

☐ Sneezing: _____

☐ Vomiting: _____

☐ Hairballs: _____

☐ Diarrhea: _____

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

If yes, where and when was your cat seen, any changes? _____

Does your cat need a nail trim today? ☐ Y ☐ N