

**Health Questionnaire**

Date: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Pet's Name: \_\_\_\_\_ Client Name: \_\_\_\_\_

**Has Your Pet Recently Exhibited**

**Any of The Following:**                      Yes   No   Comment

- Convulsions(seizures)..... \_\_\_\_\_
- Constipation..... \_\_\_\_\_
- Drinking more or less than usual... \_\_\_\_\_
- Urinating more or less than usual... \_\_\_\_\_
- Straining or crying when urinating \_\_\_\_\_
- Abnormal accidents in the house... \_\_\_\_\_
- Lumps or Bumps..... \_\_\_\_\_
- Coughing or Sneezing..... \_\_\_\_\_
- Abnormal Breathing..... \_\_\_\_\_
- Bad Breath, Abnormal teeth/gums \_\_\_\_\_
- Weight loss or gain..... \_\_\_\_\_
- Exercise intolerance..... \_\_\_\_\_
- Increased or decreased appetite... \_\_\_\_\_
- Lameness or limping..... \_\_\_\_\_
- Scratching, licking, rubbing..... \_\_\_\_\_
- Scratching ears or Shaking head... \_\_\_\_\_
- Discharge..... \_\_\_\_\_
- Scooting, licking rear end/tail..... \_\_\_\_\_
- Unexplained change in behavior... \_\_\_\_\_
- Vomiting and/or Diarrhea..... \_\_\_\_\_

**Has your pet ever:**

- Had an injury or accident..... \_\_\_\_\_
- Had surgery..... \_\_\_\_\_
- Had prolonged illness..... \_\_\_\_\_
- Had an allergic reaction to a medication or vaccine..... \_\_\_\_\_
- On a special diet or medication... \_\_\_\_\_

**Is your pet currently on or receiving: (List brand/type)**

- Prescribed medication..... \_\_\_\_\_
- Flea control..... \_\_\_\_\_
- Heartworm prevention..... \_\_\_\_\_
- Vitamin supplement..... \_\_\_\_\_
- Treats..... \_\_\_\_\_
- Table scraps/human food..... \_\_\_\_\_
- Microchipped?..... \_\_\_\_\_

What brand of food do you give? \_\_\_\_\_ How much? \_\_\_\_\_

Do you feed one or two times a day or leave bowl full? \_\_\_\_\_

Additional concerns, comments or questions? \_\_\_\_\_

\_\_\_\_\_