**Pre exam Patient Questionnaire**

Date \_\_\_\_\_\_\_\_\_\_\_\_ Owner’s Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cat’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit/ Primary concern \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEEDING

1. Do you directly observe your cat while he or she eats? YES NO NOT REALLY
	1. If so you can tell if he or she gets her/his fair share of food? YES NO
2. What do you currently feed your cat? (Check all that apply)

 CAN DRY PEOPLE FOOD TREATS

1. Does your cat prefer: DRY CANNED BOTH EQUALLY

IF CANNED FOOD IS FED:

Is the amount:

* Precisely measured and fed once daily?
* Precisely measured and split into 2+ meals a day?
* Estimated once daily?
* Estimated and split into 2+ meals a day?
* Not measured and always available
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If measured, how much is fed? \_\_\_\_\_Ounces/day \_\_\_\_\_Cans/feeding

Type of food (please include brand, type and flavor: i.e. Science Diet Adult Indoor chicken)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your cat eat all the canned offered? YES NO

IF DRY FOOD IS FED:

Is the amount:

* Precisely measured and fed once daily?
* Precisely measured and split into 2+ meals a day?
* Estimated once daily?
* Estimated and split into 2+ meals a day?
* Not measured and always available
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If measured, how much is fed? \_\_\_\_\_Cups/day \_\_\_\_\_Cups/feeding

Type of food (please include brand, type and flavor: i.e. Science Diet Adult Indoor chicken) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your cat eat all the dry offered? YES NO

1. If treats are fed, what kind and how many per day?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If people food is fed, how much and what type?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have there been any recent diet changes?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Strength | Dose | Last Given | Need Refill? |
| example: medication name | X mg | How many per day? | Last dose was when? | Yes/no |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Is your cat currently on flea preventative? YES NO

 If yes, which brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LITTER BOX:

1. Litter type: CLAY CLUMPING SCENTED UNSCENTED Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Litter box type: COVERED UNCOVERED BOTH LINER USED
3. Number of litter boxes: \_\_\_\_\_\_\_\_\_
4. Location of litter boxes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_
5. How often is litter box scooped?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. How often is litter changed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOUSEHOLD:

1. Does your cat go outside: Not At All Sneaks Outside Free Roam

 Enclosed Structure Unsupervised outside in non-enclosed areas but primarily indoor

 Walks on leash/Harness (outside with supervision)

1. Pets in household: # CATS \_\_\_\_\_\_\_\_ # DOGS \_\_\_\_\_\_\_\_\_\_ OTHER \_\_\_\_\_\_\_\_\_\_
2. Do other pets in household go outside? \_\_\_\_\_\_\_\_\_\_\_

 BEHAVIOR: Please indicate if your cat has any of the following

|  |  |
| --- | --- |
| * Increased activity level
 | * Decreased activity level
 |
| * Increase in appetite
 | * Decrease in appetite
 |
| * Increased water consumption
 | * Decreased water consumption
 |
| * Weight Gain
 | * Weight loss
 |
| * Vomiting food Bile Clear liquid hairballs other\_\_\_\_\_\_\_\_

Frequency of vomiting \_\_\_\_\_\_\_\_\_\_\_\_\_ Has frequency changed Yes No | * Diarrhea
 |
| * Constipation
 |
| * Straining or frequent trips to the litter box
 |
| * Elimination outside of the litter box
 |
| * Bad breath
 | * Vaccine reactions
 |
| * Difficulty chewing
 | * Change in sleeping habits
 |
| * Change in attitude or interaction
 | * Sneezing
 |
| * Increase in vocalizing
 | * Coughing
 |
| * Does not seek attention/petting as previously
 | * Nasal Discharge
 |
| * Weakness
 | * Eye Discharge
 |
| * Trouble walking
 | * Trouble Breathing
 |
| * Decreased jumping ability
 | * Scratching
 |
| * Stiffness
 | * Hair loss
 |
| * Wobbly gait
 | * Licking
 |
| * Tremors
 | * Hair clumps
 |
| * Shaking
 | * Sores
 |
| * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Lumps
 |

Please describe the above noted changes (i.e. when you first noted, how often it occurs, is it worse/better, etc.)