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 normal	___	___	_____
Urinating more or less than normal	___	___	_____
Straining or crying when urinating	___	___	_____
Accidents in the house by a trained pet	___	___	_____
Lumps or Bumps	___	___	_____
Coughing or Sneezing	___	___	_____
Abnormal Breathing	___	___	_____
Bad Breath, Abnormal Teeth or Gums.	___	___	_____
Weight loss or gain	___	___	_____
Exercise intolerance	___	___	_____
Increased or decreased appetite	___	___	_____
Hair loss	___	___	_____
Excessive scratching, licking, rubbing.	___	___	_____
Lameness or Limping	___	___	_____
Scratching ears or Shaking head	___	___	_____
Discharge	___	___	_____
Scooting, licking rear end/tail	___	___	_____
Unexplained change in behavior	___	___	_____
Vomiting	___	___	_____
Diarrhea	___	___	_____

HAS YOUR PET EVER:			
Had an injury or accident	___	___	_____
Had Surgery	___	___	_____
Had a prolonged illness	___	___	_____
Had an allergic reaction to food Or an insect bite	___	___	_____
Had an allergic reaction to a Medication or Vaccine	___	___	_____
Been on a special diet or medication	___	___	_____

IS YOUR PET CURRENTLY ON OR RECIEVING: (List name brand/type)			
Prescribed Medication	___	___	_____
Flea Control	___	___	_____
Heartworm Prevention	___	___	_____
Vitamin Supplement	___	___	_____
Treats	___	___	_____
Table Scraps/human food	___	___	_____

MICROCHIPPED? ___ ___

ADDITIONAL COMMENTS:

What brand of food do you give?_____ Grain Free? Yes___ No____

How much?_____Do you feed once, twice daily or leave the bowl full?_____

Additional concerns, comments or questions_____