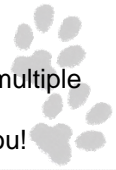


Give us some important information on your cat.



Please note: The doctor will need this form completed prior to examining your cat. If you are bringing in multiple cats at one time, please fill out one form per cat. You may fax it in to **251-8636** or email it to **allcatsclinic@sbcglobal.net** if needed or bring it with you at the time of your appointment. Thank you!

Date: _____ Cat's Name: _____ Owner's Name: _____

Planned Procedure: _____

Habitat: Indoor Only Mostly Indoor Outdoor Only Mostly Outdoor In & Out freely

Appetite: Very Good Good Erratic Picky Poor Very Poor Any changes in appetite? Up Down

Diet: Eats specific meals Food left out % of table food: _____ % of treats: _____ % of dog food (if any): _____

Type of food(s)/treat(s): _____

Water Consumption: Drinks normally Drinks LESS than normal Drinks MORE than normal Notes: _____

Activity Level: Very Active Normal Very Inactive/Lethargic MORE LESS active than usual

Last vaccines: _____ Any history we should know about your cat? _____

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you board your cat?
<input type="checkbox"/>	<input type="checkbox"/>	Does your cat frequent cat shows ?
<input type="checkbox"/>	<input type="checkbox"/>	Lameness? Which leg(s)? _____ <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Duration
<input type="checkbox"/>	<input type="checkbox"/>	Behavior: Any notable change? _____
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting: If yes, how often: _____ What is vomited? _____ Is there a relationship to eating? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea: <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently If yes, how often: _____ If yes, number of times per day: _____ Did you bring a sample? <input type="checkbox"/> Y or <input type="checkbox"/> N Is the cat straining to defecate: <input type="checkbox"/> Y or <input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/>	Coughing: <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing: If yes, how often: _____
<input type="checkbox"/>	<input type="checkbox"/>	Nasal Discharge: <input type="checkbox"/> Pus <input type="checkbox"/> Watery <input type="checkbox"/> Bloody Duration: _____
<input type="checkbox"/>	<input type="checkbox"/>	Itching: If yes, <input type="checkbox"/> Seasonal <input type="checkbox"/> Year-Round Location on cat's body: _____
<input type="checkbox"/>	<input type="checkbox"/>	History of Fight Wounds: _____ How many in the last 2 years? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has tested positive for <input type="checkbox"/> Feline Leukemia <input type="checkbox"/> Feline AIDS (FIV) <input type="checkbox"/> Not tested
<input type="checkbox"/>	<input type="checkbox"/>	Fleas or ticks noted: _____
<input type="checkbox"/>	<input type="checkbox"/>	On flea or tick prevention: If yes, type: _____ <input type="checkbox"/> Regularly or <input type="checkbox"/> Irregularly
<input type="checkbox"/>	<input type="checkbox"/>	On heartworm prevention: If yes, type: _____ <input type="checkbox"/> Regularly or <input type="checkbox"/> Irregularly

Summary of your Concerns _____

_____ Medications regularly taken: _____

Has your phone number or address changed recently? Y or N New Information: _____

Signature: _____ Contact #: _____