Pre exam Patient Questionnaire

You play a vital role in your pet's health and happiness!! We can provide the best care possible with the following information you provide by filling out this form. This will help us recognize health problems as early as possible.

THE CAT HOSPITAL OF ORLANDO

Owner's Names_____ Date _____

Owners Ph. # _____ Cat's Name_____

Reason for visit/ Primary concern

FEEDING

1. Do you directly **observe your cat while he or she eats**, If so you can tell if he or she gets her/his fair share of food? ☐ YES ☐ NO ☐ NOT REALLY
2. What do you currently feed your cat? (Check all that apply) ☐ CAN ☐ DRY ☐ PEOPLE FOOD ☐ TREATS
3. Does your cat prefer: ☐ DRY ☐ CANNED ☐ BOTH EQUALLY

4. IF *DRY* FOOD IS FED:

a. 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_____

b. If measured, how much is fed?
_____Cups/day _____Cups/feeding

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

d. Does your cat eat all the dry food offered? _____

5. IF *CANNED* FOOD IS FED:

a. Is the amount:

- ☐ Precisely measured and fed once daily?
- ☐ Precisely measured and split into 2+ meals a day?
- ☐ Guesstimated once daily?
- ☐ Guesstimated and split into 2+ meals a day?
- ☐ Not measured and always available
- ☐ Other_____

b. If measured, how much is fed?
_____ounces/day _____cans/feeding

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

d. Does your cat eat all the canned food offered? _____

6. If treats are fed; what kind and how many per day? _____
7. If people food is fed; how much and what type? _____
8. Have there been any recent diet changes? _____
9. Is your cat currently on flea preventative? If yes, which brand? _____

CURRENT MEDICATIONS:

NAME	STRENGTH	DOSE	LAST GIVEN	NEED REFILL
example: medication name	X mg	How many per day?	Last dose was when?	Yes/no

Continued on back →

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)
2. Pets in household: # CATS _____ # DOGS _____ OTHER _____
3. Do other pets in household go outside? _____

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

☐ Vaccine reactions
☐ Increased activity level
☐ Increased appetite
☐ Increased water consumption
☐ Weight Gain
☐ Bad breath
☐ Constipation
☐ Straining or frequent trips to the litter box
☐ Vomiting food
☐ Vomiting hairballs
☐ Vomiting liquid

Frequency of vomiting _____

Has frequency changed _____

☐ Decreased activity level
☐ Decrease in appetite
☐ Decreased water consumption
☐ Weight loss
☐ Difficulty chewing
☐ Diarrhea
☐ Trouble walking
☐ Lack of coordination
☐ Weakness
☐ Shaking
☐ Difficulty getting up
☐ Does not seek attention/petting as previously
☐ Stiffness

Does this stiffness resolve with movement _____

☐ Less inclined to walk
☐ Wobbly gait
☐ Decreased jumping ability
☐ Tremors
☐ Difficulty sitting down
☐ Coughing
☐ Sneezing
☐ Trouble breathing
☐ Change in sleeping habits
☐ Change in attitude or interaction
☐ Change in how the cat jumps or climbs
☐ Resents being handled
☐ Elimination outside of the litter box
☐ Change in the amount and/or frequency of urine or stool
☐ Scratching
☐ Licking
☐ Hair loss
☐ Hair clumps
☐ Lumps
☐ Sores

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