Reason for today’s visit:

_____________________________________________________________________________________________________________________________________

(please continue on reverse if needed).

When did the problem begin; describe progression:

_____________________________________________________________________________________________________________________________________

What areas of the body are affected?

_____________________________________________________________________________________________________________________________________

How is your pet for examinations?

_____________________________________________________________________________________________________________________________________

Please describe any past illnesses:

_____________________________________________________________________________________________________________________________________

Mark any current symptoms:

☐ coughing ☐ sneezing ☐ vomiting ☐ diarrhea ☐ not eating well ☐ weight loss

☐ weight gain ☐ excessive drinking ☐ excessive urination ☐ fatigue ☐ lethargy ☐ eye discharge ☐ behavioral change

☐ other: __________________________________________

List other animals your pet has contact with:

_____________________________________________________________________________________________________________________________________

Is your pet currently on flea/tick preventative? List type and frequency:

_____________________________________________________________________________________________________________________________________

Do any humans in the home have skin problems?

_____________________________________________________________________________________________________________________________________

How itchy is your pet? ☐ mild ☐ moderate ☐ severe

What symptoms do they have? ☐ scratching ☐ rubbing ☐ licking ☐ biting

The problem is: ☐ year round ☐ seasonally unknown When is it the worst? ☐ spring ☐ summer ☐ fall ☐ winter

Ear symptoms? ☐ foul smell ☐ discharge ☐ scratching right ear ☐ scratching left ear ☐ head shaking

Ear Medications: __________________________________________

Diet: Food usually fed (brand) __________________________________________ ☐ canned ☐ semi-moist ☐ dry

Is your pet on any supplements?

_____________________________________________________________________________________________________________________________________

Has your pet had a food trial? ☐ Yes ☐ No Length of trial? ____________

Which foods were in the trial?

_____________________________________________________________________________________________________________________________________

Has your cat eaten anything other than the food listed above (including people food, treats)? ☐ no ☐ yes, describe:

_____________________________________________________________________________________________________________________________________

How frequently do you bathe and with what?

_____________________________________________________________________________________________________________________________________

List any known food or drug sensitivity:

_____________________________________________________________________________________________________________________________________

Is your pet on any medications? ☐ no ☐ yes ____________________________ ☐ prescription ☐ over the counter

Please list current and past drugs. Indicate if they helped the problem:

_____________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________

Passionate Care. Meaningful Relationships.