

FELINE MEDICAL HISTORY FORM

Owner: _____	Date: _____	
Pet Name: _____	Breed: _____	
Color: _____	Age / Birthdate: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> Neutered <input type="checkbox"/> F <input type="checkbox"/> Spayed

ABOUT YOUR CAT

1. <i>Your cat was obtained from:</i> <input type="checkbox"/> Breeder <input type="checkbox"/> Pet store <input type="checkbox"/> Friend <input type="checkbox"/> Stray <input type="checkbox"/> Humane Soc. <input type="checkbox"/> Other
2. <i>Your cat is:</i> <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor - free roaming <input type="checkbox"/> Both <i>Number of cats in household:</i> _____
3. <i>Brand of pet food:</i> _____ <input type="checkbox"/> Canned <input type="checkbox"/> Dry
4. <i>How is your cat's appetite:</i> <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____ <i>How is your cat's attitude:</i> <input type="checkbox"/> Happy-Active-Normal <input type="checkbox"/> Depressed-Lethargic <input type="checkbox"/> Other: _____ <i>Is your cat drinking:</i> <input type="checkbox"/> Normally <input type="checkbox"/> More <input type="checkbox"/> Less than usual.
5. <i>Do you notice any of the following:</i> <input type="checkbox"/> Limping <input type="checkbox"/> Eye Discharge <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Shaking head <input type="checkbox"/> Scooting <input type="checkbox"/> Scratching <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Lumps <input type="checkbox"/> Bad breath often <input type="checkbox"/> Weight loss <input type="checkbox"/> Lethargy / weakness <input type="checkbox"/> Seizures <input type="checkbox"/> Hair loss
6. <i>Your cat uses the litter box:</i> <input type="checkbox"/> Consistently <input type="checkbox"/> Usually <input type="checkbox"/> Digs and covers in the litter box <input type="checkbox"/> Urinating outside litter box <input type="checkbox"/> Defecating outside litter box _____ <i>Do you notice straining, crying out or pain when using the litter box:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes

YOUR CAT'S MEDICAL HISTORY

1. <i>Previous veterinary hospital:</i> _____ <i>May we request your records from their office?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> First visit to a veterinarian
2. <i>Has your cat had the following in the last 12 months:</i> Physical examination: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Dental examination and cleaning: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Feline Leukemia Virus test: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Feline Immunosuppressive Virus test: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Fecal sample test: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Blood testing for thyroid, kidney & liver function: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
3. <i>Has your cat been vaccinated for the following in the last 12 months:</i> Rabies: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Feline Distemper: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure Feline Leukemia: <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
4. <i>Has your cat been dewormed in the last 12 months:</i> <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure
5. <i>Flea & tick preventative(s):</i> _____ <input type="checkbox"/> Collar <input type="checkbox"/> None
6. <i>Are you familiar with geriatric care for cats over 7 years of age:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
7. <i>Are you familiar with feline heartworm disease:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
8. <i>Current medications and allergies:</i> _____

COMMENTS: _____

