



PATIENT CONSULTATION QUESTIONNAIRE

Why is your pet being seen today? (i.e., vomiting, diarrhea, lethargy, scratching ears, etc.) _____

How long has the problem been going on? _____

Are you aware of anything that may have caused the symptoms? (i.e., my pet got into the trash, my pet fell while getting out of the car, etc.) _____

Is your pet's...

- | | | | |
|----------|---------------------------------|------------------------------------|------------------------------------|
| Activity | <input type="checkbox"/> normal | <input type="checkbox"/> increased | <input type="checkbox"/> decreased |
| Appetite | <input type="checkbox"/> normal | <input type="checkbox"/> increased | <input type="checkbox"/> decreased |
| Thirst | <input type="checkbox"/> normal | <input type="checkbox"/> increased | <input type="checkbox"/> decreased |

Is your pet...

- | | | | | | | |
|-----------|------------------------------|-----------------------------|---------|--------------------------------|-------------------------------------|---|
| Coughing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes: | <input type="checkbox"/> clear | <input type="checkbox"/> productive | <input type="checkbox"/> other: _____ |
| Sneezing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes: | <input type="checkbox"/> clear | <input type="checkbox"/> mucoid | <input type="checkbox"/> other: _____ |
| Vomiting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes: | <input type="checkbox"/> food | <input type="checkbox"/> bile | <input type="checkbox"/> other: _____ |
| Diarrhea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes: | <input type="checkbox"/> soft | <input type="checkbox"/> liquid | <input type="checkbox"/> bloody <input type="checkbox"/> mucoid |

Is your pet's mobility (i.e., any lameness, weakness, dragging toes, etc.)

normal abnormal

If abnormal, please describe: _____

Does your pet have...

- | | | | |
|-------------------|------------------------------|-----------------------------|-----------------|
| Any new masses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, where?: |
| Any skin lesions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, where?: |

DIET & TREATS

What do you feed your pet (please provide name brand and formula of diet)? _____

Grain-free? Yes No Raw? Yes No

What is the volume of food you offer per day? _____ How often is your pet fed? Free fed 1x/day 2x/day Other: _____

What kind of treats do you offer your pet? _____ How often are treats offered? _____

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DENTAL CARE

What do you do to help maintain the health of your pet's teeth at home? (i.e., brushing, dental chews, etc.) _____

How often? _____

When was your pet's last dental cleaning? _____ Were dental x-rays performed?: Yes No Don't know

MEDICATIONS

Is your pet on any current...

Medications? Yes No If yes, please list here: _____

Supplements (i.e., glucosamine, omega fatty acids, CBD, etc.)? Yes No If yes, please list here: _____

Heartworm prevention? Yes No If yes, please list here: _____

Flea and tick prevention? Yes No If yes, please list here: _____

OTHER

Percentage of time your pet spends: Indoors? _____% Outdoors? _____%

Has your pet traveled outside the area in the past 12 months? Yes No If yes, where? _____

Do you plan for your pet to travel outside the area in the coming 6 months? Yes No If yes, where? _____

Pet Insurance? Yes No If yes, name of insurance company? _____

**If you are interested, the Cardiff Animal Hospital will submit claims on your behalf. Please provide us with a blank claim form with your pet's information pre-printed on it, and we will fax it in after each visit.*

Are there other pets in the household? Yes No If yes, please provide name, species, and age of each: _____

Does your pet have a microchip? Yes No Not sure

If yes, we will scan it at the time of each examination to ensure it is working.

If no, did you know that the new microchips can also provide us with your pet's body temperature?

ADDITIONAL COMMENTS
