Campbell Road Veterinary Services

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Pet Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-20 lb	7	15	22	29	36	40	44	48	52	56	60	64	**68**	**72**	**76**	**80**	**84**	**88**	**92**	**96**
20-50 lb	7	16	23	30	37	42	47	51	56	60	65	**69**	**74**	**78**	**83**	**87**	**92**	**96**	**101**	**105**
50-90 lb	8	17	25	32	40	45	50	55	61	**66**	**72**	**77**	**82**	**88**	**93**	**99**	**104**	**109**	**115**	**120**
>90 lb	9	18	26	34	42	49	56	64	**71**	**78**	**86**	**93**	**101**	**108**	**115**	**123**				
	Adult					**Middle Age**							**Senior**							

As illustrated, our animal companions age much more quickly than we do. For this reason, routine physical examinations are an extremely important part of maintaining your pet's health and quality of life. You are your pet's most important advocate. Please assist our medical staff to provide a thorough assessment of your pet's health by completing this questionnaire. One of our veterinary technicians will gladly help you if you are unsure how to answer certain questions.

Veterinary Health History

1. Has pet had ANY history of vaccine reactions Yes/No If yes please explain

2. Does your pet have any known allergies to medications/food etc. Yes/No If yes please explain

3. Does you pet have any ongoing health concerns? Yes/No Please explain.

4. Is your pet on any medications/special diets? If so please list them below.

Diet and Environment

1. What food does patient currently eat? Please include table food here and all treats, chewies etc. Brand of food and amount & frequency?

2. Any recent diet changes?

3. What material is your food and water bowl made from (i.e. plastic, stainless steel etc)

4. Does patient consume treats? **Yes / No** What kinds?

5. Is patient on any dietary supplements? **Yes / No** If so, what kind and what dosage?

6. Is patient primarily indoor or outdoor? If a cat does it go outside at all?

7. Are there any other animals in the household? **Yes / No** If so, are any of them sick?

8. Do you board your pet? **Yes / No** If so, how often?

9. Does your pet travel with you? If so why do you go?

10. Do you have your pet groomed or bathed outside of your home? **Yes / No** If so, how often?

Review of Signs

1. Has patient exhibited any attitude or behavior change? **Yes / No** Please explain.

2. Has patient ever had seizures? **Yes / No** Please explain.

3. Any recent weight changes? **Yes / No** Please explain.

4. Any recent appetite changes? **Yes / No** Please explain.

5. Does patient have any exercise intolerance? **Yes / No** Please explain.

6. Has patient exhibited any signs of lameness? **Yes / No** Please explain

7. Does patient have difficulty rising after lying down? **Yes / No** Please explain.

8. Does patient have any increased thirst and/or urination? **Yes / No** Please explain.

9. Has patient had a decrease in urination? **Yes / No** Please explain.

10. Has patient had any changes in bowl movements? Consistency? Frequency? Changes in appearance? Blood? Mucus? Please explain

11. Has patient been vomiting? **Yes / No** Please explain.

12. Has patient been coughing? **Yes / No** Please explain.

13. Has patient been sneezing? **Yes / No** Please explain.

14. Has patient been itching? **Yes / No** Please explain.

15. Has patient had any recent hair loss? **Yes / No** Please explain.

16. Does patient have any growths on body? **Yes / No** Please explain.

17. Does patient have any discharge from nose, eyes, vulva, etc.? **Yes / No** Please explain

18. Has patient had any change in sleep patterns? **Yes / No** Please explain.

19. Has patient been leaking urine? i.e. wet spots where they are lying or dribbling urine **Yes/No** Please explain

20. Has patient been experiencing any signs such as burping, passing gas, and loud stomach gurgling? **Yes/No** Please explain

21. Has patient experienced any ear problems, licking feet, rectum, vulva, and hot spots? **Yes/No** Please explain

22. Has patient been experiencing any low energy, large bowl movements, more than two bowl movements per day, poor haircoat, dry flaky skin, bad breath, excessive shedding, hairballs (vomited or passed in the stool)?
Yes/No Please explain

23. Has patient been experiencing any other signs you are worried about? **Yes/No** Use the space below to jot down any concerns or questions you have?

24. For cats only. Any changes in litter box habits? i.e. not using the box, defecating or urinating near but outside the box, etc. **Yes/No** Please explain

Reason for Visit (For sick patients)

1. When did the problem start or how long has the problem been occurring?

2. What were the first signs of the problem and how did it progress?

3. Was the patient seen by another doctor for this problem? **Yes / No** If so, when?

4. Were any treatments given by you or another doctor? **Yes / No** If so, what and at what dosage?

Past History (For new patients)

1.How long have you had the patient? _____ If you acquired patient recently, from where?

2. Has patient traveled recently (within 6 months)? **Yes / No** If so, where and when?

3. Has your pet been microchipped? **Yes / No** If so, has the microchip been registered?

4. Is patient on flea prevention? **Yes / No** If so, what type and how often?

5. Is patient on heartworm prevention? **Yes / No** If so, what type and how often?

6. Has patient been tested for heartworms? **Yes / No** If so, when?

7. Has the patient been exposed to ticks? **Yes / No** Please explain.

8. Is patient used for hunting? **Yes / No** Is patient taken camping or on outdoor trips? **Yes / No**

9. Is patient used for breeding? **Yes / No** If so, is she pregnant or is he currently standing? **Yes / No**

11. Has patient had any prior illnesses, accidents, or surgeries? **Yes / No** Please explain

12. Is patient aggressive or fearful around strangers? **Yes / No** Please explain.

13. Aside from heartworm, flea & tick preventatives, is patient given any other medication? Yes / No Please explain.

14. Does patient have any known allergies to any medications? Yes / No If yes, please list:

15. Has patient ever had a reaction to any vaccines? **Yes** / **No** If yes, please list and explain below:

16. Is anyone in contact with your pets allergic to any medications? **Yes/No** If so, what medications

17. Does you pet come in contact with young children, babies, elderly people, immune compromised persons, females that are pregnant or attempting to become so? **Yes/No** If so parasite control is extremely important in your household

18. . Do you keep reptiles, amphibians or birds as pets? **Yes/No** If so please indicate what you keep.