CHICOPEE HILLS ANIMAL HOSPITAL

The following questionnaire is designed to help you and your veterinarian provide the best care for your pet.

Cat: **Owner:**

Please indicate your preferred method of contact, and best time to reach you (i.e. mail, email, home, cell or work phone #):

Preferred method(s) of contact:_____ Best time:_____

Habitat: ◯ Indoor only ◯ Occasionally outside ◯ Outdoor only ◯ Mostly outdoor ◯ In and out freely ◯ Travel or Cottage

Appetite ◯ Good ◯ Erratic ◯ Picky ◯ Poor

Diet: What does your cat eat daily? (Meals / snacks / treats / people food etc.) Please include brand & quantity, if known.

_____

_____

Raw Diet: Please indicate if you feed your cat raw meat (including pet store or homemade raw diets) ◯ Yes ◯ No

Raw diets are a health and safety concern for our patients and staff. Please notify us if your pet consumes a raw diet so that we may take appropriate precautions.

Activity level: ◯ Active ◯ Normal ◯ Inactive **Change in Activity Level:** ◯ Increased ◯ Decreased

YES	NO	**(**Please √ yes/no and circle anything applicable**)**
◯	◯	Is your cat receiving any **supplements** or **over the counter medicine?**
◯	◯	Has your cat **received veterinary care at any other veterinary hospital(s) in the past year**?
◯	◯	Do you have any **plants in your house**?
◯	◯	Is your cat protected by **Pet Insurance**?
◯	◯	Are there any **additional pets** in your household?
◯	◯	Are there any **young children** or **individuals with compromised immune systems** in your household?
◯	◯	Does your cat **hunt and/or eat** animals such as rodents or rabbits?
◯	◯	Will your cat go to a **boarding kennel, cat shows,** or **does it have exposure to other cats**?
◯	◯	**Lameness/Mobility:** any limping, trouble with stairs, stiffness, pain, spending more time lying down?
◯	◯	**Behavior:** any change? Reduced family interaction, increased vocalization, loss of litter training?
◯	◯	**Digestion:** any vomiting, diarrhea or constipation?
◯	◯	**Urination:** any change in frequency/quantity etc?
◯	◯	**Breathing:** any coughing/wheezing, sneezing, nasal discharge, mouth breathing?
◯	◯	**Odours:** any bad breath, odour from ears or skin?
◯	◯	**Senses:** any hearing, smelling or vision loss?
◯	◯	**Growths:** any new growths, changes in previous growths?
◯	◯	**Skin/Hair Coat:** any itchiness, dandruff, dull coat, hair loss, matting?
◯	◯	**Fleas or ticks:** any noticed recently?
◯	◯	On **flea preventative**? If so, how often do you give it? _____

Medications: _____

Summary of your concerns:

_____

_____