

CHICOPEE HILLS ANIMAL HOSPITAL

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

Dog:

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: Leash Walks Fenced Backyard Cottage Out of Country Off -Leash

Appetite: Good Erratic Picky Poor

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

Raw Diet: Please indicate if you feed your dog 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 \checkmark yes/no and circle anything that applies**)

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Is your dog receiving any supplements or over the counter medicine ? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your dog received veterinary care at any other veterinary hospital(s) in the past year ? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any plants in your house ? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your dog protected by Pet Insurance ? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there any additional pets in your household? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there any young children or individuals with compromised immune systems in your household? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your dog hunt and/or eat animals such as rodents or rabbits? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your dog go to boarding kennels or dog shows/trials or dog parks or doggy daycare ? |
| <input type="checkbox"/> | <input type="checkbox"/> | Lameness/Mobility: any limping, trouble with stairs, stiffness, pain, spending more time lying down? |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavior: any change? Reduced family interaction, increased vocalization, loss of house training? |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestion: any vomiting, diarrhea, constipation? |
| <input type="checkbox"/> | <input type="checkbox"/> | Urination: any change in frequency/colour etc? |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing: any coughing, shortness of breath, wheezing, exercise intolerance, mouth breathing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Odours: any bad breath, odour from ears or skin? |
| <input type="checkbox"/> | <input type="checkbox"/> | Senses: any hearing, smelling or vision loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | Growths: any new growths, changes in previous growths? |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin/Hair Coat: any itchiness, dandruff, dull, hair loss, matting? |
| <input type="checkbox"/> | <input type="checkbox"/> | Fleas or ticks noted recently? |
| <input type="checkbox"/> | <input type="checkbox"/> | On heartworm preventative ? If so, how often do you give it? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | On flea preventative ? If so, how often do you give it? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | On tick preventative ? If so, how often do you give it? _____ |

Medications: _____

Summary of your concerns:

