



FELINE – CAT Medical Questionnaire

The Human's Information

Last Name: _____ First Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Cell Phone: _____ Txt Msg Alt. Phone: _____ Txt Msg
 Email: _____
 How did you hear about us? _____

The Cat's Information

Name: _____
 Age - Years: _____ Months: _____ Boy or Girl Fixed
 Breed: _____ Color: _____

Lifestyle

How much time does your cat spend outside? _____ Hours
 Does your cat go to the groomer, or boarding facilities? _____ No Yes
 How many animals do you have in your household? _____ Dogs _____ Cats
 _____ Other - Explain _____
 Are there any animals in the household that spend the majority of time outdoors? _____ No Yes

Medical History

Has your cat ever had any of the following?
 Vomiting or Diarrhea? No Yes
 Coughing or Sneezing? No Yes
 Discharge from eye(s) or nose? No Yes
 History of fleas or ticks? No Yes
 History of seizures, muscle tremors, loss of coordination, or shaking No Yes
 Reactions to anesthesia, vaccines or other medications? No Yes
 Is your cat on any medication currently? No Yes
 Does your cat have any allergies (i.e. foods, drugs)? No Yes
 When was your cat last vaccinated Feline Respiratory Combo (FVRCP/3-in-1)? _____
 Rabies? _____
 Feline Leukemia virus? _____
 Is your cat...
 on Flea and Tick preventative? No Yes
 on Heartworm preventative? No Yes
 Microchipped No Yes

SURGERY Specific

Has your cat had any previous surgeries? No Yes

For Female Cats only

Has your cat had a recent heat? No Yes
 Has your cat had kittens? No Yes

Services needed

Vaccines ----->	FVRCP \$20	Rabies \$20	FeLV \$20
Microchip \$35	Deworming \$15	Blood work \$65	IV Catheter and Fluids \$30
Nail Trim \$5-\$10	Ear Mite Treatment \$35	FeLV/FIV Testing \$35	Or Subcutaneous fluids \$15

For support of blood pressure and hydration

PLEASE BRING ANY MEDICAL RECORDS YOU HAVE SO WE MAY HAVE A COMPLETE PICTURE OF YOUR CAT'S HEALTH

FOR OFFICE USE:

Date:	Input <input type="checkbox"/> Exam <input type="checkbox"/>	Wt	Temp	Pulse	Resp.	DKT:		ml	Inv <input type="checkbox"/> AL <input type="checkbox"/> V <input type="checkbox"/>
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