

FELINE – CAT MEDICAL QUESTIONNAIRE

OWNER'S Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Phone: _____ Text; Alt. Phone: _____ Text

Cat's Information

Name: _____ Boy or Girl Fixed

Breed: _____ Color: _____

Age in Years: _____ and Months: _____ or DOB: _____

How much time does your Cat spend outside? Hours: _____

Does your Cat go to the groomer, or boarding facilities? Yes No

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? Yes No

Has the cat ever had any of the following?

Vomiting or Diarrhea? Yes No

Coughing/Sneezing? Yes No

Discharge from eye(s) or nose? Yes No

History of fleas or ticks? Yes No

Seizures/muscle tremors/shaking Yes No

Reactions to anesthesia, vaccines or other medications? Yes No

Is the cat on any medication currently? Yes No

Has the cat had any previous surgeries? Yes No

Any allergies (i.e. foods, drugs)? Yes No

When was the cat last vaccinated for...

● FVRCP/3-in-1? _____

● Rabies? _____

● Feline Leukemia virus? _____

● Other Vaccines? _____

Female Cats only

Has the cat had a recent heat? Yes No

Has the cat had kittens? Yes No

OTHER SERVICES & PRODUCTS

FVRCP - 25

FELV - 30

Rabies - 22

Pre-surgery blood testing - 75

FELV/FIV Test - 45

ISO Microchip - 40

Deciduous/"Baby-Teeth" - 20

Ear Mite Treatment - 35

Nail Trim - 15

Subcutaneous fluid therapy - 20

Tape Worms - 35

Anal Gland Expression - 20

Intravenous (IV) Fluid Therapy - 40

Rounds and Hookworms - 20

E-Collar - 15

FOR OFFICE USE:

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