WELLNESS QUESTIONNAIRE

Owners full name: _____ ***Patients Name:*** _____

Primary Concern: _____

When was the problem(s) first noticed? _____

Has your pet ever been treated for this concern?: _____

Has your pet been vomiting? ☐ No ☐ Yes Frequency:_____

Has your pet had diarrhea? ☐ No ☐ Yes Frequency:_____

Has your pet been coughing? ☐ No ☐ Yes Frequency:_____

Has your pet been scratching? ☐ No ☐ Yes Location: _____

Has your pet been licking/chewing themselves? ☐ No ☐ Yes Frequency:_____

Has your pet experienced hair loss? ☐ No ☐ Yes Severity: _____

How is your pets'…..

Appetite ☐ Normal ☐ Increased ☐ Decreased Comments: _____

Drinking ☐ Normal ☐ Increased ☐ Decreased Comments: _____

Urination ☐ Normal ☐ Increased ☐ Decreased Comments: _____

Activity level ☐ Normal for age ☐ Decreased ☐ Lethargic ☐ Hyperactive

Is your pet experiencing any soreness/limping? ☐ None Location: _____

Comments: _____

Does your pet have any lumps/bumps you would like the doctor to examine? ☐ No ☐ Yes

Location: _____ Comments: _____

Any known allergies? ☐ No ☐ Yes Allergies: _____

Food/Diet:

What brand name AND formula do you feed your pet? _____

How many cups of food per day does your pet eat? _____

How many times a day does your pet eat? _____

Medications:

Is your pet on heartworm prevention? ☐ No ☐ Yes **Brand name:** _____

Is your pet on flea/tick prevention? ☐ No ☐ Yes **Brand name:** _____

Is your pet on any other medications or supplements? _____