Respiratory/Cardiac Questionnaire

1) If your pet's history (i.e. vaccines etc.) is not with us, which hospital should we contact?

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2) Does your pet spend any time outdoors? ( ) Yes ( ) No What percent each day? _______ __________
( ) Fenced yard ( ) Leash walk ( ) Free roam

3) What is your pet's diet? _____________ How much? ____________________Any recent changes? ________

4) Does your pet receive any medications or supplements? (Prescribed or OTC) ( ) Yes ( ) No

If yes, what medication and how much? ____

Heartworm Prevention ___________________________________ Date of last dose ______________

Flea/Tick Prevention ____________________________________ Date of last dose ______________

5) Habits / Symptoms

Urination:	( ) Normal	( ) Increased	( ) Decreased
Defecation:	( ) Normal	( ) Increased	( ) Decreased
Eating:	( ) Normal	( ) Increased	( ) Decreased
Drinking:	( ) Normal	( ) Increased	( ) Decreased
Vomiting:		( ) Yes	( ) No
Diarrhea:		( ) Yes	( ) No
Coughing:		( ) Yes	( ) No
Sneezing:		( ) Yes	( ) No
Scratching/Chewing/Licking:		( ) Yes	( ) No

6) Is your pet sneezing ( ) Yes ( ) No How long? ___________________________
Nasal discharge ( ) Yes ( ) No Color of discharge? ____________________

7) Eye discharge? ( ) Yes ( ) No Color of discharge? ____________________
Are eyes matted ( ) Yes ( ) No
Are eyes red/irritated? ( ) Yes ( ) No
Do eyes look swollen ( ) Yes ( ) No

8) Is your pet coughing ( ) Yes ( ) No
Having difficulty breathing? ( ) Yes ( ) No
Wheezing? ( ) Yes ( ) No
Get winded easily? ( ) Yes ( ) No
Any gurgling sounds when breathes? ( ) Yes ( ) No

9) Has you pet had any fainting spells? ( ) Yes ( ) No When? ____________________________
If yes, explain ____

PLEASE CHOOSE ONE OF THE OPTIONS BELOW AND SIGN

I give the Doctor permission to do bloodwork, radiographs, or any medication that she may deem necessary.

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Please call me if the Doctor needs to do any additional treatment or medication.

________________________________ *Contact number* ________________________________