

# Mid Atlantic Cat Hospital

## Wellness History

### Cat

Name \_\_\_\_\_ Age \_\_\_\_\_

### Owner

Name \_\_\_\_\_ Date \_\_\_\_\_

Please take a moment to complete the following history, which will allow us to recognize health concerns as early as possible.

How much time does your cat spend outside? \_\_\_\_\_

Circle which best describes your cat				For how long?	
Attitude:	Normal	Lethargic	Hyperactive	_____	
Appetite:	Normal	Increased	Decreased	_____	
Drinking:	Normal	Increased	Decreased	_____	
Coughing:	None	Occasional	Frequent	_____	
Vomiting:	None	Occasional	Frequent	_____	
Sneezing:	None	Occasional	Frequent	_____	
Urination:	Normal	Increased	Decreased	_____	
Diarrhea:	Yes	No		_____	
Constipation:	Yes	No		_____	
Bad Breath:	Yes	No		_____	
Jumping or Climbing:	Normal	Having Trouble		_____	
Parasite Control:	None	Revolution	Advantage	Frontline	Heartguard
Brand of Food:	Canned _____			Dry _____	
Total Amount Fed Per Day:	Meal Fed _____			Free Choice _____	
Litter Type:	Clay	Clumping	Other	Scented	Unscented
Litter Box:	Covered	Uncovered	Liner	No Liner	
Number of Litter Boxes in the House:	_____				
How Often Scooped?	_____		How Often Changed?	_____	
Microchipped?	Yes	No			

Are there any other particular concerns you would like to discuss with the doctor today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please continue on the back if your cat is 7 years or older*

# Senior Wellness History

Please complete this side if your cat is 7 years or older

<b>Circle which best describes your cat</b>				For how long?
<b>Weight:</b>	Gaining	Losing	No Change	_____
<b>Activity:</b>	Increased	Decreased	No Change	_____
<b>Coordination:</b>	Increased	Decreased	No Change	_____
<b>Weakness:</b>	Yes	No		_____
<b>Pacing:</b>	Increased	Decreased	No Change	_____
<b>Muscle Tremors or Shaking:</b>	None	Occasional	Frequent	_____
<b>Skin Problems:</b>	Yes	No		_____
<b>Sore Gums or Difficulty Eating:</b>	Yes	No		_____
<b>House Soiling (Urine or Feces):</b>	None	Occasional	Frequent	_____
<b>Confusion:</b>	None	Occasional	Frequent	_____
<b>Affection:</b>	Increased	Decreased	No Change	_____
<b>Aggression:</b>	Increased	Decreased	No Change	_____
<b>Anxiety or Fear:</b>	Increased	Decreased	No Change	_____
<b>Hearing:</b>		Decreased	No Change	_____
<b>Grooming:</b>	Increased	Decreased	No Change	_____
<b>Vocalization:</b>	Increased	Decreased	No Change	_____
<b>Waking Family at Night:</b>	None	Occasional	Frequent	_____

Please provide additional details such as when you first noticed the change and how severe the condition may be: \_\_\_\_\_

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