River County Animal Wellness, LLC
Medical Questionnaire

Client Name:_____ Patient Name:_____

Primary Complaint:_____

Medication(s):_____

How long has illness been present: _____

Circle all that apply:

Preference for: Warm Areas Cold Areas Unknown As expected for the season

Personality: Hyperactive Outgoing Confident Strong Quiet Timid Less Confident Laid-Back

Thirst: Drinks a lot at once Small drinks often Not Thirsty

Appetite: Good/Normal Always hungry Picky eater Not eating regular food

What are you feeding? _____

What will your pet eat? _____

Stool: Normal Dry Bloody Foul Smelling Soft Loose Diarrhea Accidents in the house
Color: _____ Same as normal? Yes No How often? _____

Urine: Short stream Strong Odor Bloody Long Stream Leakage/Dripping Accidents in the house
Color: _____ Same as normal? Yes No How often? _____

Cough: None Dry Wet Loud Quiet/Weak Worse at: Daytime Night time All the time

Vomiting: None Frequent Sporadic Color: _____ Smells like: _____
Just after eating Some time later Large amount Small amount
Describe what you saw: _____

Greets strangers: Barks Attacks Wags tail warmly Slow reaction Does not care Runs away Hides

Pet is: Patient Excitable Irritable Vocal Mellow/Laid Back Follows the rules Insecure/Fearful

Prefers: Soft beds/surfaces Hard beds/surfaces

Sleep: Sleeps a lot Sleeps very little Vocalizes or wakes up owner at night Muscle jerking during sleep
Dreams

Stiffness: None Sudden onset Constant **Worse:** Morning Evening Cold weather Hot weather
Damp weather Before Walks After walks

Any crying/whimpering with movement or activity? _____

Massage: Likes Does not like

Weight:

Putting your hands on your pet's sides, can you feel his/her ribs? Yes No

Do you give your pet table scraps or leftovers from your meals? Yes No

Is your pet exercised regularly? Yes No

What type of exercise does your pet get? _____

How often do you exercise your pet? _____

Does your pet continue eating as long as there is food in the dish? Yes No

Has anyone ever told you your pet looks heavy? Yes No

Skin Problems:

Date or Age of onset of problems: _____

Primary complaint: _____

Is your pet on any medication? Yes No If yes, what kind? _____

When are the clinical signs worse? (Circle One) All Year Winter Spring Summer Fall

Is your pet (circle all that apply): Scratching Biting Rubbing Chewing Licking

What areas are affected? (Circle all that apply): All Over Face Feet Ears Armpits Rump Belly

Is your pet doing any of the following? Wheezing Sneezing Coughing Other _____

Does your pet have any of the following? (Circle all that apply):

Swelling Redness Hair Loss Scales Skin color changes Sores Hives Change in weight Vomiting

Diarrhea Odor Change in thirst Change in appetite

Where does your pet live? Indoors Outdoors Both

Where does your pet sleep? _____

What type of bedding does your pet sleep on? _____

Does your pet have fleas now or ever had fleas? Yes No If yes, when? _____

Have there been changes in the pet's environment? _____

Have you moved recently? Yes No From: _____ To: _____

Are there other pets in the household? Yes No What kind? _____

Does your pet have any other medical problems? Yes No
If yes explain:_____

What treatments have been used to control your pet's problem?

Steroids Antihistamines Shampoo or rinse Antibiotics Type & Dose:_____

How effective was the therapy? _____

Any known medication sensitivities (including topical and shampoo)? _____