Patient ID _____

PLEASE PRINT OUT, COMPLETE, AND BRING TO ANNUAL APPOINTMENT

Patient Name_____ Owner Name_____ Date_____

FELINE

ANNUAL HISTORY AND RISK FACTOR EVALUATION

For us to evaluate your cat it is very important that you are his/her voice. We will use this information to evaluate your cat's health and individualize the care your cat receives, including vaccinations and examinations. For Numbers 1-7, please check next to the one that best describes your cat's lifestyle.

My cat:

1. Is allowed to go outside ( ) occasionally escapes ( ) Stays indoors at all times ( )

2. Lives with other cats ( ) Lives in a one-cat household ( )

3. Attends cat shows Sometimes ( ) Never ( )

4. Goes to the kennel Sometimes ( ) Never ( )

5. Has access to the food dish, water bowl, or litter box of other cats Sometimes ( ) Never ( )

6. Comes into contact with other cats Sometimes ( ) Never ( )

7. I may get another cat Soon ( ) Maybe ( ) Never ( )

Please answer the following to the best of your knowledge:

Appetite	Decreased ( )	Normal ( )	Increased ( )
Weight	Loss ( )	Normal ( )	Gain ( )
Water consumption	Decreased ( )	Normal ( )	Increased ( )
Bowel movements	Constipation ( )	Normal ( )	Diarrhea ( )
Urination	Decreased ( )	Normal ( )	Increased ( )

Straining to urinate	Yes ( )	No ( )
Incontinence (loss of housetraining)	Yes ( )	No ( )
Vomiting	Yes ( )	No ( )
Coughing	Yes ( )	No ( )
Sneezing	Yes ( )	No ( )
Gagging	Yes ( )	No ( )
Listless	Yes ( )	No ( )
Weakness	Yes ( )	No ( )
Shaking head	Yes ( )	No ( )
Scratching	Yes ( )	No ( ) Location: _____
Hair loss	Yes ( )	No ( ) Patchy ( ) Generalized ( )
Excessive shedding	Yes ( )	No ( )
Flea prevention used	Yes ( )	No ( )
Heartworm prevention used	Yes ( )	No ( )
Scooting	Yes ( )	No ( )
Lumps or bumps	Yes ( )	No ( )
Bad breath	Yes ( )	No ( )
Unusual discharge	Yes ( )	No ( ) Location: _____
Lameness	Yes ( )	No ( ) Leg: RF( ) LF( ) RR( ) LR( )
Difficulty rising	Yes ( )	No ( )
Difficulty climbing stairs	Yes ( )	No ( )
Behavioral changes	Yes ( )	No ( ) Describe: _____
Currently on medication	Yes ( )	No ( ) Name: _____