Annual Patient Questionnaire

Owner ______________________________ Patient ____________________ Date _______________

1. Where does your pet live? Indoors Outdoors Both
2. How long have you had your pet? _____________________________________
3. Are there other pets in the household? If yes, please indicate the type and number.
   a. Dog _____
   b. Cat _____
   c. Bird _____; type(s) ____
   d. Other exotics _____; type(s) ____
   e. Horses _____
   f. Livestock _____; type(s) ____
4. Is your pet on a commercial pet food? Yes No If yes, please indicate the brand/type:
   ____
5. Does your pet receive any treats? Yes No If yes, please indicate the brand/type:
   ____
6. Does your pet receive any home cooking? Yes No
7. Does your pet receive vitamins? Yes No
8. Do you provide your pet with any nutritional supplements or nutraceuticals? Yes No
9. What medications does your pet receive?____
   ____
10. What herbal products does your pet receive? ____
    ____
11. Is your pet on Flea Medication? Yes No If yes, please indicate type & frequency:
    ____
12. Do you have plans to board your pet in the next year? Yes No
13. Has your pet ever traveled outside of western Washington, to your knowledge? Yes No If yes, please tell us where: ____
14. Do you plan to travel outside of western Washington with your pet in the next year? Yes No
15. Are you aware if your pet has ever had an adverse reaction to any vaccinations or medications? If yes, please explain. ____
    ____
16. Please indicate if you have noticed any of the following conditions or symptoms in your pet:
    Loose Stool/Diarrhea ___ Vomiting ___ Coughing ___ Labored Breathing ___ Sneezing ___
    Eye/Nose Discharge ___ Itching ___ Hair Loss ___ Fleas ___ Ticks ___ Skin growths ___
    Lumps/Bumps ___ Bad Breath ___ Difficulty Eating ___ Itchy/Smelly ears ___ Scooting ___
    Weight loss ___ Change in behavior ___ Change in sleep pattern ___ Weight gain ___
    Change in water consumption ___ Change in food consumption ___ Painful ___ Stiff ___
    Slow to rise ___ Licking/Chewing ___ Head shaking ___ Vision changes ___ Weakness ___
    Activity change ___ Urination/Defecation changes ___

Internal Use Only Last Fecal Exam ______ Last BW ______ Last UA ______ Rabies ______
Da2PPL ______ PRCC ______ FeLV ______ Lepto ______ Bordetella ______

Thank you for taking the time to fill out this questionnaire so that we may better address your pet's needs.