Civic Feline Clinic

Drop-Off Patient Information

Owner Name: _____ Date: _____

Patient Name: _____ Indoor/Outdoor (circle one)

Please describe the problem including when it started, the symptoms you are observing and the duration of symptoms. Is this a chronic or previously-treated condition? Yes ❑ No ❑

List all medications your cat is currently taking, including topical flea treatments, if any.

What is your cat's current diet? _____

Have you noticed:

Weight loss? Yes ❑ No ❑
Decreased appetite? Yes ❑ No ❑
Increased water consumption? Yes ❑ No ❑
Vomiting? Yes ❑ No ❑
Diarrhea? Yes ❑ No ❑
Respiratory difficulty? Yes ❑ No ❑
Coughing? Yes ❑ No ❑
Abnormal urination? Yes ❑ No ❑
Abnormally large volume of urine? Yes ❑ No ❑

Weight Gain? Yes ❑ No ❑
Increased appetite? Yes ❑ No ❑
Constipation? Yes ❑ No ❑
Panting/gasping? Yes ❑ No ❑
Sneezing? Yes ❑ No ❑
Straining to urinate or defecate? (circle one)
Blood in urine or stool? (circle one)

Owner Signature: _____ Phone Number: _____