

QUESTIONNAIRE FOR SENIOR WELLNESS VISIT

m M		DATE:		PET'S NAME:
TO SOLVEN		NAME	:	AGE:
Z/A/Z	~	ADDR	ESS:	SPECIES:
MAL HOSPITS		CITY, S	STATE, ZIP:	SEX:
TU HOS		TELEP	HONE NUMBER:	SPAYED/NEUTERED
		_		
Have you noticed	any o	change		
		circle)	(explanation/comments)	
DRINKING:	YES			
URINATION:	YES	- 1 - 1		
APPETITE:	YES	NO		
WEIGHT:	YES	NO		
VOCALIZATION: (especially cats)	YES	NO		_
ENERGY:	YES	NO		
DISORIENTATION:	YES	NO		
AGGRESSION:	YES	NO		
SLEEP CYCLE:	YES	NO		
ANXIETY:	YES	NO		
SIGHT/VISION:	YES	NO		
HEARING:	YES	NO		
Is your net curren	tlu		(description, strength, frequency, dosing)	
Is your pet curren on any medication	tly ns	1		
Is your pet curren on any medication or supplements?	tly ns	2		
on any medication or supplements?	ns	2		
on any medication	ns	2		
on any medication or supplements?	ns	2 3 4		
on any medication or supplements?	ns	2 3 4		
on any medication or supplements?	ns	2 3 4		
on any medication or supplements?	ns	2 3 4 5		
on any medication or supplements? (please circle) YES NO What is your pet's	ns	2 3 4		
on any medication or supplements? (please circle) YES NO What is	ns	2 3 4 5		
on any medication or supplements? (please circle) YES NO What is your pet's	ns	2 3 4 5		
on any medication or supplements? (please circle) YES NO What is your pet's current diet?	ns F(2 3 4 5	(brand/quantity per day, extras)	
on any medication or supplements? (please circle) YES NO What is your pet's current diet?	FO	2 3 4 5 DOD:		
on any medication or supplements? (please circle) YES NO What is your pet's current diet?	FO	2 3 4 5 DOD:	(brand/quantity per day, extras)	
on any medication or supplements? (please circle) YES NO What is your pet's current diet? Has your pet been	FO expe (please YES	2 3 4 5 DOD:	(brand/quantity per day, extras)	
on any medication or supplements? (please circle) YES NO What is your pet's current diet? Has your pet been VOMITING: DIARRHEA:	FO expe (please YES YES	2 3 4 5 DOD: riencin circle) NO NO	(brand/quantity per day, extras)	
on any medication or supplements? (please circle) YES NO What is your pet's current diet? Has your pet been vomiting:	rexpe (please YES YES	2 3 4 5 DOD:	(brand/quantity per day, extras)	



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Have you noticed any new masses or bumps on your pet? (please circle) YES NO					
(If yes, please put a circle on the picture indicating the mass or bump)					
() 3, ,					
CANINE FELINE DORSAL VENTRAL VENTRAL					
How love has it have there					
How long has it been there:					
Has your pet shown any signs of limping or lameness? (please circle) YES NO (If yes, please describe which limb/how often)					
Has your pet shown reluctancy to jump on or off furniture, beds, in or out of car or climbing stairs? (please circle) YES NO					
(If yes, please describe)					
Has your pet been itchy lately? (please circle) YES NO (If yes, please describe where they are scratching the most)					
Has your pet been having accidents in the house? (please circle) YES NO					
(If yes, please describe)					
For cats, inappropriate eliminations outside the litter box?					

Thank You!

Your time and honest answers will help us to help your pet be Happy, Healthy and Pain Free for as long as possible.

The Doctors and Staff Rippowam Animal Hospital