



# CAT Health History

Patient Name: \_\_\_\_\_ Client Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your address & phone number still correct?  Yes  No  
 Does this pet have Medical Insurance?  Yes  No  
 Is your cat Microchipped?  Yes  No

What is your current email ? \_\_\_\_\_  
 May we email reminders ( no spam)? \_\_\_\_\_

WERE YOU ASKED TO BRING A STOOL SAMPLE TODAY?  Yes  No

**Chief Complaint or Reason for Visit:**

**Current Medications/ Nutritional Supplements/ Vitamins and how often:**

\_\_\_\_\_

DIET (brand and canned/dry/pouches): \_\_\_\_\_

Snacks/ People food  No  Yes \_\_\_\_\_

Vaccinations given within the last year?  Yes  No

Lifestyle: Indoor % \_\_\_\_\_ / Outdoor % \_\_\_\_\_

Dental Care (toothbrushing/ greenies/ etc)? \_\_\_\_\_

Allergic Reaction to Medication?  No  Yes What \_\_\_\_\_

Adverse Reaction to Vaccination?  No  Yes Which \_\_\_\_\_ When \_\_\_\_\_

Adverse Reaction to Food?  No  Yes What \_\_\_\_\_

	Norm	Abnorm	Describe
Appetite			
Drinking			
Bowel Movements			
Urination			
		NO YES	DESCRIBE (how often, for how long, where)
Vomiting			
Diarrhea			
Coughing			
Sneezing			
Loud Breathing Noises			
Bad Breath			
Lumps / Bumps			
Scotting			
Excess Licking/ Scratching			
Hair Loss			
Shaking Head			
Unusual Discharge			
Lameness/ Stiffness			
Difficulty Rising			

-----Office Use only-----

Wt \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

FVRCP  FELV  RABIES 1 yr 3 yr \_\_\_\_\_

FECAL  ADLT SCR N  SR SCR N  TNT  FELV/FIV TEST

OTHER \_\_\_\_\_

CSR \_\_\_\_\_

Tech \_\_\_\_\_