

# FELINE PATIENT INFORMATION

Thank you for taking the time to provide us with information about your cat.



Client Name: \_\_\_\_\_ Cat's Name: \_\_\_\_\_

Sex:  Male  Female Neutered/Spayed?  Yes  No

Breed: \_\_\_\_\_ Coat Color: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ If unknown, approximate age: \_\_\_\_\_

Has your cat had bloodwork/urinalysis in past 2 years?  No  Yes When? \_\_\_\_\_

Has your cat ever had its teeth cleaned?  No  Yes When? \_\_\_\_\_

Does your cat have any chronic ailments? \_\_\_\_\_

Prior surgeries? \_\_\_\_\_

Does your cat take any medications? \_\_\_\_\_

What diet do you feed your cat? \_\_\_\_\_  Wet  Dry

Do you give your cat treats?  No  Yes What? \_\_\_\_\_

Do you give your cat human food?  No  Yes What? \_\_\_\_\_

Method of flea prevention used:  None  Frontline  Advantage  Other: \_\_\_\_\_

Is your cat licensed? # \_\_\_\_\_ Microchipped? # \_\_\_\_\_

Is your cat:  Inside Only  Both Inside and Outside  Outside Only

Where did you obtain your cat? \_\_\_\_\_ When? \_\_\_\_\_

Has your cat been tested for AIDS or Leukemia?  No  Yes When? \_\_\_\_\_

Does your cat have a history of vomiting?  No  Yes How often? \_\_\_\_\_

Has your cat ever had its blood pressure checked?  No  Yes When? \_\_\_\_\_

Has your cat had a fecal exam (parasite check) in the past two years?  No  Yes

Please share your cat's vaccine history with us:

Vaccine	Date Vaccinated	Clinic Name
Rabies		
Upper Respiratory-Distemper		
Feline Leukemia		
Other:		
Other:		