



FELINE HISTORY FORM

Pet's Name: _____ Client: _____ Date: _____

Breed: _____ Color: _____

Sex: **M – F - Unsure** Neutered: **Yes – No – Unsure** Declawed: **Yes - No**

Is this your first cat? **Yes – No** Date of birth _____ (Circle): **actual - estimate**

When did you get your pet? _____

Source: **Pet Store / Pet Show / Breeder / Private Party / Shelter / Other** _____

Vaccines (Date Administered):

Rabies (____/____/____) **1 year – 3 year** (Circle)

FVRCP (Distemper) (____/____/____) FeLV (____/____/____)

Feline Viral Tests: FeLV **pos – neg – untested** FIV **pos – neg – untested**

FIP pos – neg – untested

Has your cat ever had a vaccine reaction? **Yes – No**

Have you had Vaccine Titers done rather than annual shots?: **Yes – No**

Which vaccines?: _____ Dates: _____

Environment and Litter Box Habits:

Does your cat go outside? **No, never. - Yes, backyard only. - Yes, into neighborhood.**

Does your cat use the litter box reliably?: **Yes – No**

If not, describe the problem: _____

What type of litter do you use? **Clay – Clumping – Other:** _____

Is the litter box: **Covered - Uncovered**

Toys: _____

Other Pets in the Home: _____

Are they exposed to this pet? **Y – N** In what way? _____

Nutrition

Diet (detail everything offered) _____

List everything your pet eats: _____

Vitamin & Mineral Supplements: _____

Medical History

List current medical problems / Primary Complaint: _____

Current treatments or supplements: _____

Please list any previous medical problems (dates & treatment)

Current Appetite: **Normal – Increased – Decreased – Anorexic**

Describe (duration, progression, severity): _____

Stools: **Color** _____ **Consistency** _____ **Amount** _____ **Frequency** _____

Urination: **Color** _____ **Frequency** _____ **Amount** _____

Have you noticed (Circle all that apply):

weight loss, weight gain, masses or lumps (where _____)

abnormal urination, abnormal stools, vomiting, other discharge _____

difficult breathing, coughing, sneezing, nasal discharge _____

excessive shedding, hair loss, itching, skin sores (where _____)

shaking head, rubbing ears, smelly ears (which side _____)

poor posture, head tilt, loss of balance, limping (which leg _____)

lethargy, inactivity, pain (where _____)

Describe other changes: _____

Previous Veterinary Visits: **Yes – No**

Date of last visit _____

Doctor _____

Clinic _____

Phone _____

Records requested? **Y – N** Received? **Y – N**

Previous Lab Tests / Diagnostics: **Y – N**

Date of Last Testing _____

Complete Blood Count O Chemistry Profile O Fecal Exam O Urinalysis O

Bacterial Culture O Radiograph (X-ray) O Other Tests _____

Results Requested? **Y – N** Received by Clinic? **Y - N**