Mid Atlantic Cat Hospital
Wellness History

Cat
Name_____ Age _____

Owner
Name_____ Date _____

Please take a moment to complete the following history, which will allow us to recognize health concerns as early as possible.

How much time does your cat spend outside? _____

Circle which best describes your cat

				For how long?
Attitude:	Normal	Lethargic	Hyperactive	_____
Appetite:	Normal	Increased	Decreased	_____
Drinking:	Normal	Increased	Decreased	_____
Coughing:	None	Occasional	Frequent	_____
Vomiting:	None	Occasional	Frequent	_____
Sneezing:	None	Occasional	Frequent	_____
Urination:	Normal	Increased	Decreased	_____
Diarrhea:	Yes	No		_____
Constipation:	Yes	No		_____
Bad Breath:	Yes	No		_____
Jumping or Climbing:	Normal	Having Trouble		_____

Parasite Control: None Revolution Advantage Frontline Heartguard

Brand of Food: Canned _____ Dry _____

Total Amount Fed Per Day: Meal Fed _____ Free Choice _____

Litter Type: Clay Clumping Other Scented Unscented

Litter Box: Covered Uncovered Liner No Liner

Number of Litter Boxes in the House: _____

How Often Scooped? _____ **How Often Changed?** _____

Microchipped? Yes No

Are there any other particular concerns you would like to discuss with the doctor today? _____

_____

_____

Please continue on the back if your cat is 7 years or older

Senior Wellness History

Please complete this side if your cat is 7 years or older

Circle which best describes your cat

				For how long?
Weight:	Gaining	Losing	No Change	_____
Activity:	Increased	Decreased	No Change	_____
Coordination:	Increased	Decreased	No Change	_____
Weakness:	Yes	No		_____
Pacing:	Increased	Decreased	No Change	_____
Muscle Tremors or Shaking:	None	Occasional	Frequent	_____
Skin Problems:	Yes	No		_____
Sore Gums or Difficulty Eating:	Yes	No		_____
House Soiling (Urine or Feces):	None	Occasional	Frequent	_____
Confusion:	None	Occasional	Frequent	_____
Affection:	Increased	Decreased	No Change	_____
Aggression:	Increased	Decreased	No Change	_____
Anxiety or Fear:	Increased	Decreased	No Change	_____
Hearing:		Decreased	No Change	_____
Grooming:	Increased	Decreased	No Change	_____
Vocalization:	Increased	Decreased	No Change	_____
Waking Family at Night:	None	Occasional	Frequent	_____

Please provide additional details such as when you first noticed the change and how severe the condition may be: _____

_____

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