FELINE WELLNESS ASSESSMENT

VCA Animal Hospitals

Appointment date: _____

Owner's name: _____ Email: _____

Cat's name: _____ Cat's date of birth: _____ Cat breed: _____

Home phone: _____ Cell phone: _____

Pets in household (list number) Cats _____ Dogs _____ Others _____

List % of time spent: Indoors: _____ Outdoors: _____ If outdoors: ❑ Free roaming ❑ Supervised at all times ❑ Not always supervised

Please check (✓) the appropriate box for the following questions:	Yes	No	Not sure
Changes in attitude or activity level?			
Any change in sleeping habits (more, less, different locations)?			
Any change in interaction with the family/other pets?			
Any signs of stress: hiding, awake more, withdrawn?			
Difficulty jumping, rising, going up stairs, reluctance to exercise?			
Any weakness, incoordination, or shaking?			
Any changes in behavior? (vocalization, aggression, anxiety, etc.)			
Any confusion, disorientation, bumping into things?			
Change in appetite? (increase, decrease)			
Change in water consumption? (increase, decrease)			
Any weight loss or gain?			
Straining to urinate, or urinating outside the box?			
Blood in the urine, or any change of color?			
Any difficulty breathing, sneezing or coughing?			
Sore gums, bad breath, or difficulty chewing?			
Any vomiting, hairballs, or trouble swallowing?			
Straining to defecate or had accidents in the house?			
Any diarrhea or soft stool?			
Blood or mucous in the stool?			
Ears are sore, itchy, or have an unpleasant odor?			
Changes in the eyes? (discharge, cloudiness, redness, etc.)			
Any hair loss, sores, lumps, scratches, or changes in grooming?			

What other changes in your cat's behavior or health have you noticed? _____

Litter Box Information Type used: _____ Number of boxes: _____ Locations: _____

Number of hooded boxes: _____ Unhooded boxes: _____ Sizes (dimensions) of litter boxes: _____

Are you finding more or less urine in the box(es) than usual? ❑ Yes ❑ No ❑ Not sure

Diet Information Brand: _____ Type: _____ Amount when fed: _____

General Information Date of last Wellness visit: _____

Do you know if bloodwork/urinalysis was done at that visit? ❑ Yes ❑ No ❑ Not sure

Date of last parasite treatment (fleas/intestinal worms/heartworms): _____