DAY ROAD
Animal Hospital

Check-in Questionnaire

Date of Appointment: Patient's Name:

Owner's Last Name: Owner's First Name:

Patient's Age: 1 Weeks Neutered Ma

Is your pet coughing? Yes (●) No ( ) If yes, when did it start:

Is your pet sneezing? Yes (●) No ( ) If yes, when did it start:

Is your pet vomiting? Yes (●) No ( ) If yes, when did it start:

How often? Hourly

Time of day? Morning

How is your pet's stool? Normal If stool is abnormal, when did it start:

Frequent urination? Yes ( ) No (●) If yes, when did it start:

Are they urinating in smaller or larger amounts? No Change

More or less frequently? No Change

Are they having accidents while awake or asleep? No Accidents

Is your pet's water intake Increase

Is your pet's appetite Increase

What is your pet's regular diet? Wet and Dry

How often do they eat?

How much do they eat a day?

Does your pet get treats? Yes (●) No ( ) What type of treats?

Is your pet on flea, tick, heart worm and parasite prevention? Yes (●) No ( ) What kind of parasite prevention?

What is your primary concern for today's visit? When did it start? Has there been any changes? Is it getting better or worse?

Is your pet on any medications or supplements? If yes, please list medications below and **how they are being given:**

Medications/Treatments/Supplements	Strength	Number of Tablets	How Often

Do you plan on boarding your pet in the next year? Yes ◯ No ◯

Do you travel outside of Western Washington with your pet? Yes ◯ No ◯

If yes, where do you travel to with your pet?

If your pet is a feline are they a: Inside Only