Grafton Animal Hospital *Pocket Pet* Wellness Health Questionnaire

To help us make the proper recommendation to you concerning your pet's health care needs please complete the following questionnaire.

Pet's name: _____ Species: _____ DOB: _____ Date: _____

A) Lifestyle Circle your best response**:**

1. **If you are new to our practice** do you have specific knowledge regarding previous care (illnesses, feedings, etc…)?
   Yes No N/A
2. Please list the name and city of your previous veterinary clinic: _____
3. I have the following number of pets: **Dogs-____; Cats-____; Other: _____**

Please 4. My pocket pet lives in a (please circle): **indoor cage 100% mostly indoor cage mostly outside cage**

Circle 5. My pocket pet is allowed out of cage to move around the house: (**unsupervised / supervised) never rarely frequently**

6. My pocket pet is allowed to go outside (please circle): **never rarely frequently**
7. How long have you owned your pocket pet? _____ From where? _____

Y / N 9. I take my pet to **boarding pet shows or pet stores** (please circle all that apply). When was last visit? _____

10. Diet- Please be specific (indicate what is actually eaten, not what is fed):
    Pellets=_____ % of diet eaten Brand: _____
    Seeds = _____% of diet eaten Type: _____
    Hay = _____% of diet eaten Type: _____
    Veggies/Fruits= _____ % of diet eaten Type: _____
    Treats= _____ % of diet eaten Type: _____
11. Do you use a vitamin or mineral supplement? **Y / N** Type: _____
12. How is water provided? (Bottle, dripper, bowl, etc) _____
13. Describe the habitat (size, type, furniture, toys, etc): _____
    _____
14. What type of bedding do you use? _____

B) Owners Observations: Have you noticed any of the following (Please circle any that apply)

Y / N 1. Weight changes?
Y / N 2. Changes in appetite?
Y / N 3. Drinking more or less than normal? ↑ ↓ **(Please circle one)**
Y / N 4. Stool/droppings more or less than normal? ↑ ↓ **(Please circle one)**
Y / N 5. Lameness (limping) or Tenderness?
Y / N 6. Digestive upsets? (If yes, circle type: Vomiting, Diarrhea, Flatulence)
Y / N 7. Skin Changes?
Y / N 8. Eye discharges or changes?
Y / N 9. Sneezing, Coughing, or Drooling?
Y / N 10. Scratching, Rubbing, Self biting (biting at himself)?
Y / N 11. Ear Discharge, Head Shaking, or other Ear changes?
Y / N 12. Bad breath or other odors?
Y / N 13. Changes in sleep patterns?
Y / N 14. Changes in exercise tolerance, agility, or ability to move around? **(If YES – continue to section C-a)**
Y / N 16. Behavior Changes or Issues? **(If YES – continue to section C-b)**
Y / N 17. Do you have any other concerns you would like to discuss with the doctor today?

ALL SENIORS CONTINUE TO SECTION C

C) Seniors

a) Changes in exercise tolerance, agility, or ability to move around

Y / N 1. Has difficulty rising, sitting, or squatting to eliminate?

Y / N 2. Prefers lying to standing?

Y / N 3. Has an obvious limp?

Y / N 4. Can't move around normally?

b) Behavior Changes

Y / N 1. Disorientation (circle): stares into space, doesn't respond to you or respond to their name,

Y / N 2. Decreased interaction with family members (circle): seeks attention less, less enthusiasm upon greeting, failure to greet family members

Y / N 3. Activity and sleep changes (circle): sleeps more during the day and less at night (or vice versa if nocturnal)

Y / N 4. Is restless or has insomnia?

Y / N 5. Bites when touched?

Y / N 6. Any Tremors or Shaking?