

Veterinary Care Clinic

New Feline Patient Questionnaire

Client information:

Last Name:

First Name:

Pet information:

Name:

Breed:

Sex:

Spayed/Neutered:

Age/Birth Date:

Vaccination history and dates:

Rabies:

FVRCP (Feline Distemper):

FELV (Feline Leukemia):

Others:

Previous Veterinary Hospital Name, Location and Phone Number:

Medical History:

Has your pet been diagnosed with any of the followings (please choose as many as apply):

Allergies (please specify if known):

Liver disease

Heart disease

Dental disease

Seizures

Arthritis

Kidney disease

Asthma

Diabetes

Others:

Date and Signature: