

CANINE SENIOR CHECKUP MEDICAL RECORD

Client Instructions: Please fill out & answer the following questions as completely as possible.

Date _____

Patient's Name _____

Circle the appropriate response:

Male *Female* *Spayed/Neutered*

Breed _____

Color _____

Date of Birth or Approx. Age _____

Owner's Name _____

Owner's Address _____

City/State/Zip _____

Telephone: **Home** _____

Work _____

Cell _____

Email _____

NUTRITION/DIET INFORMATION

What brand does your pet eat? Dry, canned or moist? _____

Please describe any snacks, supplements, or table food your pet receives & how often.

Who feeds the pet? _____

How many times a day does your pet eat? _____

How is your pet's appetite? _____

Have you noticed any changes in your pets eating habits or appetite recently? _____

ENVIRONMENT

Does your pet live indoors, outdoors, or both? _____

If outdoors or both, where does your pet sleep? _____

Are there other pets in the family? If so, how many & what kind(s)? _____

Are there any young children in the family? _____

Does your pet seek warm places to lie down (heat vent, fireplace, etc?) _____

EXERCISE

What kind of exercise or playtime does your pet get and how often? _____

Please describe any problems with this exercise. Does your pet have trouble jumping? _____

Does your pet tire easily? _____

Does your pet have trouble breathing or coughing during or after exercise? _____

WEIGHT

How do you monitor your pet's weight? (Scale, visually, other?) _____

Have you noticed any recent weight loss or gain? _____

DENTAL CARE

Has your pet ever had its teeth cleaned? If so, when was the last time? How often does your pet have professional cleanings?

Do you ever brush your pet's teeth? _____

Does your pet ever seem to have trouble chewing? _____

BEHAVIOR

Have you noticed any changes in your pet's behavior? If so, please describe. _____

BEHAVIOR (continued)

Please list any behavioral problems _____

Have you recently felt your pet was (please circle all appropriate answers):

More sensitive to pain *More lethargic* *Moody*

Less Tolerant *More anxious/nervous*

More likely to disobey commands *No change*

When did you notice changes? _____

SPECIAL SENSES

Have you noticed any changes in your pet's vision? _____

Does your pet run into objects or become anxious in an unfamiliar environment? _____

Have you noticed any changes in your pet's hearing? _____

Is your pet sometimes less responsive to commands? _____

OTHER INFORMATION

How much water does your pet drink in a day? _____

Any recent changes in amount of water or frequency of drinking? _____

Any changes in amount or frequency of urination? _____

Does your pet ever dribble or leak urine? _____

Does your pet have trouble getting through the whole night without urinating or defecating? _____

Any changes in amount or frequency of your pet's bowel movements? _____

Have you noticed any limping, stiffness, or pain when your pet first gets up? Does he/she improve after awhile?

Any problems with skin or hair coat? _____

OTHER INFORMATION (Continued)

Any coughing, sneezing, discharge from nose or eyes, scratching or shaking head? _____

Any lumps or bumps? _____

Any past medical problems of which we are not aware? _____

What medications/supplements are your pet taking currently? _____
