



Pet Name: _____ Date: _____
 Species/Breed: _____ Sex: _____
 Age/DOB: _____
 Owner Name: _____
 Address: _____
 Phone: _____

Changes to Normal Activity (Check all that apply): For recheck appointments, indicate changes since the last visit.

- | | | | | |
|----------------------|---------------------------------|------------------------------------|------------------------------------|---------------------------------------|
| Appetite: | Normal <input type="checkbox"/> | Increased <input type="checkbox"/> | Decreased <input type="checkbox"/> | |
| Weight: | Normal <input type="checkbox"/> | Increased <input type="checkbox"/> | Decreased <input type="checkbox"/> | |
| Water Intake: | Normal <input type="checkbox"/> | Increased <input type="checkbox"/> | Decreased <input type="checkbox"/> | |
| Urination: | Normal <input type="checkbox"/> | Increased <input type="checkbox"/> | Decreased <input type="checkbox"/> | |
| Bowel Habits: | Normal <input type="checkbox"/> | Increased <input type="checkbox"/> | Decreased <input type="checkbox"/> | |
| Exercise: | Normal <input type="checkbox"/> | Increased <input type="checkbox"/> | Decreased <input type="checkbox"/> | |
| Vomiting: | None <input type="checkbox"/> | Daily <input type="checkbox"/> | Weekly <input type="checkbox"/> | Intermittent <input type="checkbox"/> |
| Diarrhea: | None <input type="checkbox"/> | Daily <input type="checkbox"/> | Weekly <input type="checkbox"/> | Intermittent <input type="checkbox"/> |
| Sneezing: | None <input type="checkbox"/> | Daily <input type="checkbox"/> | Weekly <input type="checkbox"/> | Intermittent <input type="checkbox"/> |
| Coughing: | None <input type="checkbox"/> | Daily <input type="checkbox"/> | Weekly <input type="checkbox"/> | Intermittent <input type="checkbox"/> |

How many times per day/week does your pet cough? _____

When did the cough start? _____

The cough has: Worsened Improved Stayed the Same

Cough Occurs: At night In the morning After activity/Excitement

After Drinking Anytime

Character of the Cough: Harsh Honking Wheezing
 Soft Wet Ends with gag

The cough affects my pet's day to day life: Yes No

Has your pet had treatment for the cough? Yes No

List each treatment and if it helped: _____

Distressed/Difficult Breathing: None Daily Weekly Intermittent

Respiratory rate at home: _____

The difficulty breathing occurs: With Excitement Activity/exercise Rest/Sleep After cough Other

Does your pet's breathing seem uncomfortable? Yes No

Fainting/Collapse Episodes: None Daily Weekly Intermittent

How many events have occurred? _____ Dates: _____

Events occurred with: Excitement Activity/exercise Rest/Sleep After cough Other

During, my pet was: Limp Stiff Trembling/Shaking Paddling Gum chewing
 Unconscious Conscious Urinated Defecated

How long did the event last? _____

How long did it take your pet to return to normal? _____

Diet: Canned Dry Both Brand _____

Treats: _____ Table Food: _____

Heartworm Prevention: Yes No Brand: _____

I administer the prevention: Every month Most months Rarely

List any other concerns about your pet's heart (use the back of the page if needed):

