Polk County Animal Hospital
General Health and Lifestyle Questionnaire

Providing complete lifestyle information about your pet will help our medical staff to make the proper recommendations in regards to complete health care and well – being.

Pet's Name: _____ Client's Name: _____ Date: _____

Species: _____ Breed: _____ Age (or Date of Birth): _____

I. Lifestyle and Condition: (circle answer)

1. My pet lives: Exclusively Indoors / Inside and Outside / Exclusively Outdoors
2. Are there young children in your household Yes / No
3. Do you have concerns about contagious diseases from other pets (neighbors, strays)? Yes / No
4. Does your pet have access to exercise / restroom areas used by other pets? Yes / No
5. Do you take your pet hiking, camping, hunting, etc.? Yes / No
6. Do you travel with your pet (automobile, RV, plane) Yes / No
7. Do you take your pet to boarding facilities, groomers, pet store, obedience school? Yes / No
8. Do you show your pet in confirmation, obedience, agility or hunting competitions? Yes / No
9. Are you considering acquiring a new pet? Yes / No

II. Owner Observations:

Have you noticed changes in any of the following (circle answer):

Weight Change	Yes / No	(if yes, please specify □ Increase □ Decrease)
Appetite	Yes / No	(if yes, please specify □ Increase □ Decrease)
Water Intake	Yes / No	(if yes, please specify □ Increase □ Decrease)
Urination	Yes / No	(if yes, please specify □ Increase □ Decrease)
Digestive Upsets	Yes / No	(if yes, please specify □ Vomiting □ Diarrhea □ Constipation)
Lameness (limping)	Yes / No	(if yes, please specify where:_____)
Hair Coat Changes	Yes / No	
Scratching / Licking	Yes / No	
Skin Odor	Yes / No	
Scooting	Yes / No	

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II. Owner Observations (continued):

Lumps or Growths	Yes / No
Excessive Cough	Yes / No
Bad Breath	Yes / No
Excessive Drooling	Yes / No
Eye Discharge	Yes / No
Eye Changes	Yes / No
Ear Odor	Yes / No
Ear Discharge	Yes / No
Ear Scratching	Yes / No
Head Tilt or Shaking	Yes / No
Sleep Routine	Yes / No
Exercise Ability	Yes / No
Tremors or Shaking	Yes / No
Disorientation	Yes / No
Aggression	Yes / No

II. Previous Medical History – (new clients or established patients that have received veterinary care elsewhere within the past 12 months)

Vaccinations: _____, _____, _____, _____

My pet takes the follow prescription medications (include heartworm / flea medications): _____
_____

Previous Surgeries / Hospitalizations:_____

Name / address of facility: _____

May we contact this facility to obtain complete medical records of your pet? Yes / No

Is this your only pet? Yes / No (numbers of other pets): Dogs:_____ Cats:_____ Others:_____

III. Additional Information or Concerns (use this space to provide our medical staff with any additional information you feel would be beneficial in better understanding your pet).

_____
_____
_____
_____
_____