



Feline Risk Assessment Questionnaire

Patton Veterinary Hospital is committed to providing quality veterinary care and feline wellness education. We know you, as owners, want to make informed decisions about your cat's health care and our staff is trained to talk to you about preventative care for felines of all ages. We understand the special role your cat plays in your family and we are dedicated to partnering with you to make healthcare decisions for your cat. By completing the following questionnaire we can help provide personal attention to the unique concerns and needs of your feline friend.

Client Name: _____ **Pet Name:** _____ **Pet Age:** _____

1. How many cats are in your household? _____
2. When is the last time your cat was outdoors? _____
3. Does your cat spend more time inside or outside? _____
4. Has your cat been tested for feline leukemia and FIV (feline AIDS) within the last year? _____
5. Has your cat ever been in a fight and/or bitten by another cat or animal? _____
6. What flea & tick preventative is your cat on and when was the last dose applied? _____
7. How many litter boxes do you have in the household and where are they located throughout your house? _____
How often are they cleaned? _____
8. Has your cat had a stool sample tested within the last year to check for worms and parasites? _____
9. Does your cat have a microchip? _____

If your cat is 7 years of age or older, please indicate if you have noticed any of the following:

- | | | | |
|--------------------------------|--|----------------------------|--|
| Difficulty climbing or jumping | yes <input type="checkbox"/> no <input type="checkbox"/> | Vomiting | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Avoidance of these activities | yes <input type="checkbox"/> no <input type="checkbox"/> | Vision problems | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Stiffness or limping | yes <input type="checkbox"/> no <input type="checkbox"/> | Loose stool/diarrhea | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Increased appetite or drinking | yes <input type="checkbox"/> no <input type="checkbox"/> | Lumps or bumps | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Decreased appetite or drinking | yes <input type="checkbox"/> no <input type="checkbox"/> | Skin or hair coat changes | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Increased urination | yes <input type="checkbox"/> no <input type="checkbox"/> | Weight loss | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Bad breath | yes <input type="checkbox"/> no <input type="checkbox"/> | Weight gain | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Changes in activity level | yes <input type="checkbox"/> no <input type="checkbox"/> | Breathing changes/coughing | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Disorientation/circling | yes <input type="checkbox"/> no <input type="checkbox"/> | Decreased interaction | yes <input type="checkbox"/> no <input type="checkbox"/> |
| Problems defecating | yes <input type="checkbox"/> no <input type="checkbox"/> | Difficulty hearing | yes <input type="checkbox"/> no <input type="checkbox"/> |