



Phone: (916) 683-4000

Fax: (916) 683-4040

FELINE DISEASE/RISK ASSESSMENT

Owner's Name (Last, First): _____

Cat's Name: _____ Nickname: _____

Primary Breed: _____ Color: _____

Sex: Male Female Spayed Neutered

Birthday or Age: _____ How long have you had this cat? _____

This cat is from: Rescue Breeder Stray Store Other _____

Previous veterinarian: _____

GENERAL HEALTH

What food are you feeding your cat? _____

How much? _____ for how long? _____

Do you feed your cat treats? Yes No

If yes, how often: _____

Currently taking medications or other supplements? Yes No

If yes, please list the medications and dosage. _____

Any significant changes in your cat's weight? Yes No

Any changes in: thirst appetite urination defecation

Please describe: _____

Chronic or recurring: vomiting diarrhea coughing sneezing

Please describe: _____

RISK ASSESSMENT

- 🐾 Your cat is kept: completely outdoors mostly outdoors completely indoors
 mostly indoors half indoor/half outdoor

- 🐾 Exposure to other cats: none very little some interaction a lot of friendly interaction gets in fights

- 🐾 Currently on heartworm medication? Yes No Which brand? _____

- 🐾 Currently on flea medication? Yes No Which brand? _____

- 🐾 Ever seen a tick on any of your pets? Yes No If yes, how long ago? _____

- 🐾 Ever had a vaccine reaction? vomiting trouble breathing hives lumps that didn't go away none

- 🐾 Does your cat have a microchip? Yes No

Anything else you would like us to know about your cat? (previous surgeries, urination problems, etc.) _____

Vaccination	Date and Name of Clinic (if known)
Rabies <input type="radio"/> Yes <input type="radio"/> No	_____
Distemper (FVRCP) <input type="radio"/> Yes <input type="radio"/> No	_____
Leukemia (FeLV) <input type="radio"/> Yes <input type="radio"/> No	_____

Date: _____

Owner Signature