






# HEALTH HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_

<b>Your Last Name:</b>		<b>Country:</b>	<b>Postal Code:</b>	<b>Cat's Name:</b>
<b>Description: Breed:</b>		<b>Color:</b>	<b>Date of Birth:</b>	<b>Weight:</b> <input type="checkbox"/> lb <input type="checkbox"/> kg
Owned for?    _____ years,    _____ months;		Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Neutered?   If yes, Date: _____		
Declawed? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, <input type="checkbox"/> Front only <input type="checkbox"/> All four paws				
<b>Body Condition</b> (please check box that looks most like your cat):				
<input type="checkbox"/> Skinny	<input type="checkbox"/> Lean	<input type="checkbox"/> Moderate	<input type="checkbox"/> Stout	<input type="checkbox"/> Obese
				
<b>Health, Medication, and Diet Information</b>				
<b>Previous Illnesses or Surgeries:</b>				
<b>Current Medications:</b>				
<b>Please check the boxes that best apply to your cat.</b>				
<b>Diet:</b> (please be as specific a name as you can ex: Buckeye Best (company) Adult Chicken and Rice (flavor))				
<b>Wet Food (Name):</b>		<input type="checkbox"/> None <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%		
<b>Dry Food (Name):</b>		<input type="checkbox"/> None <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%		
<b>General Information</b>				
<b>How many hours each day, on average does your cat spend indoors?</b> <input type="checkbox"/> Indoor Only <input type="checkbox"/> 18-24 <input type="checkbox"/> 12-18 <input type="checkbox"/> 6-12 <input type="checkbox"/> 0-6				
Is time outside supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>If you have more than one cat, what is their relationship?</b> <input type="checkbox"/> Not related <input type="checkbox"/> Littermate <input type="checkbox"/> Sibling <input type="checkbox"/> Parent-Offspring				
<input type="checkbox"/> Other:				
<b>Where did you obtain your cat</b> (source)?				
<input type="checkbox"/> Gift		<input type="checkbox"/> Purchased from a pet shop		<input type="checkbox"/> Shelter/rescue organization
<input type="checkbox"/> Purchased from a friend		<input type="checkbox"/> Offspring from a pet I already own(ed)		<input type="checkbox"/> Stray/orphan
<input type="checkbox"/> Purchased from a breeder		<input type="checkbox"/> Other:		
<b>Does your cat frequently</b> (please check all that apply):				
<input type="checkbox"/> Try to escape		<input type="checkbox"/> Pace at outside doors		<input type="checkbox"/> Cry at outside doors
<input type="checkbox"/> Hide		<input type="checkbox"/> Act fearful		
<input type="checkbox"/> Act friendly		<input type="checkbox"/> Follow owners around the home		<input type="checkbox"/> Destroy things when left alone
<input type="checkbox"/> Act "depressed" (little interest in feeding, grooming, environment, etc.)				
Chase or attack: <input type="checkbox"/> humans (hands, feet, ankles), <input type="checkbox"/> other animals				
<b>Housing:</b>				
Apartment: <input type="checkbox"/> Studio <input type="checkbox"/> 1-2 bedroom(s) <input type="checkbox"/> 3 or more bedrooms				
Number of floors or levels of the home the cat has access to: _____				
House: <input type="checkbox"/> Attached/twin duplex <input type="checkbox"/> Attached, 3 or more units <input type="checkbox"/> Single <input type="checkbox"/> Other:				
<b>Total Cats:</b>	<b>Total Dogs:</b>	<b>Other Pets:</b>		
<b>Other People:</b>				

Please help us understand what your cat does around the house by checking the box next to each behavior that best describes how commonly your cat does each of the behaviors described below.

Does your cat:	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time	Does Not Apply
Leave household articles (furniture, drapes, clothing, plants, etc.) alone.							
Eat small amounts calmly at intervals throughout the 24-hour day.							
Drink small amounts calmly at intervals throughout the 24-hour day.							
Use the litterbox.							
Get along with people in the home.							
Get along with other pets in the home.							
Remain calm when left alone.							
Stay relaxed during normal, everyday handling (grooming, petting).							
Calm down quickly if startled or excited.							
React calmly to everyday events (telephone or doorbell ringing).							
Play well with people.							
Play well with other family cats.							
Show affection without acting clingy or annoying.							
Tolerate confinement in a carrier (including travel).							
Groom entire body calmly.							
Use scratching posts.							
Play with toys.							
<b>Comments; anything else your cat regularly does or does not do that you think might be helpful for us to know about?</b>							

**Directions:** For items below, please use the following choices to describe how often your pet experiences the symptom, adding **comments/explanation** as appropriate.

<b>Score:</b>	<b>0</b> = It <b>NEVER</b> happens.	<b>3</b> = It happens <b>at least ONCE per MONTH</b>
	<b>1</b> = It has happened <b>at least ONCE</b>	<b>4</b> = It happens <b>at least ONCE per WEEK</b>
	<b>2</b> = It happens <b>at least ONCE per YEAR</b>	<b>5</b> = It happens <b>DAILY</b>

SCORE	How often does your cat:	Comments/Explanation
	Cough	
	Sneeze	
	Have discharge from the nose	
	Have difficulty breathing	
	Stop eating	
	Vomit <input type="checkbox"/> food <input type="checkbox"/> hair <input type="checkbox"/> bile <input type="checkbox"/> other	
	Have hairballs	
	Have diarrhea	
	Have constipation	
	Defecate outside the liter box	
	Strain to urinate	
	Have frequent attempts to urinate	
	Urinate outside of the liter box	
	Have blood in the urine	
	Spray urine	
	Groom more than cats usually do	
	Shed more than cats usually do	
	Scratch him/herself more than cats usually do	
	Have discharge from eyes	
	Seem fearful	
	Seem easily startled	
	Seem to need a great deal of contact or attention	
	Destroy things when left alone	

**Please check any of the following diseases your cat has been diagnosed with:**

- |  |  |
|--|--|
| <input type="checkbox"/> Periodontal (dental) disease    | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Inflammatory bowel disease      | <input type="checkbox"/> Skin disease      |
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Cardiomyopathy (heart problems) | <input type="checkbox"/> Obesity           |
| <input type="checkbox"/> Other: _____                    |  |

**Please write any additional comments about you pet's health below:**

***By submitting this form, you agree that anonymous information from it may be used for cat health-related research.***