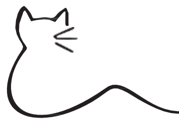
Civic Feline Clinic  **Patient Drop-Off Information**

Client Name ______________________ Patient Name ___________________ Date ________

Describe the problem, when you first noticed it, any symptoms you have noticed, and how long each has lasted.

What diet are you currently feeding?

List all medications, including topical flea treatments, you are currently administering.	
Medication (name/dose/frequency/time given)	Last Given

Does your cat go outside? Yes ❑ No ❑

Have you noticed:

Weight loss?	Yes ❑	No ❑	Sneezing?	Yes ❑	No ❑
Decreased appetite?	Yes ❑	No ❑	Coughing?	Yes ❑	No ❑
Increased appetite?	Yes ❑	No ❑	Increased respiratory rate?	Yes ❑	No ❑
Increased water consumption?	Yes ❑	No ❑	Panting?	Yes ❑	No ❑
Vomiting?	Yes ❑	No ❑	Abnormal urination?	Yes ❑	No ❑
Diarrhea?	Yes ❑	No ❑	Straining to urinate?	Yes ❑	No ❑
Constipation?	Yes ❑	No ❑	Excessive urine volume?	Yes ❑	No ❑
Difficulty breathing?	Yes ❑	No ❑	Blood in urine?	Yes ❑	No ❑
Nasal discharge?	Yes ❑	No ❑	Have we treated your cat for this condition before?	Yes ❑	No ❑

_________________________________ Owner Signature

_______________ Date