HISTORY QUESTIONS that I recommend to help me to help you the most:

(The form my lovely technicians always loved to fill in… a bit tedious but eliminates most follow-up questions they may have forgotten to ask.)

Problem (cause for visit):

o Onset of problem (approximate duration): \_\_\_\_\_\_

o Treatments given so far for condition: \_\_\_\_\_\_

• Response to above treatments (improvement or no? initial improvement only to relapse after cessation of treatment? etc)

Details Please….

1) Gastrointestinal tract:

• Vomiting or regurgitating? \_\_\_\_\_\_

o Frequency (times per day, days per week or month) and for how long (weeks, months, years?) \_\_\_\_\_\_

o Contents (food, bile, foam, blood) \_\_\_\_\_\_

o Is there retching and abdominal contractions or is food passively expelled like a "spit up episode"? \_\_\_\_\_\_

• Weight loss? If yes, how much, over what time frame: \_\_\_\_\_\_

• Appetite? (if abnormal, for how long?): \_\_\_\_\_\_

• Diarrhea? Abnormal stool appearance?

o Volume? (large, normal, small amounts?) \_\_\_\_\_\_

o Frequency: how many times per day? Multiple small piles per movement or one large amount? \_\_\_\_\_\_

o Straining? Mucus? Blood (frank)? \_\_\_\_\_\_

o Color of feces? \_\_\_\_\_\_

2) Respiratory:

Coughing, sneezing, nasal discharge? Increased respiratory rate or effort? Noisy respiration?

• If coughing, under what circumstances (with exercise? at rest? after drinking? what time of day?) \_\_\_\_\_\_

• If sneezing- frequency, duration; seasonal? \_\_\_\_\_\_

• If nasal discharge:

o Unilateral or bilateral? \_\_\_\_\_\_

o Duration? appearance of discharge? \_\_\_\_\_\_

o Noisy respiration noted? \_\_\_\_\_\_

3) Urogenital:

o Frequency of urination: \_\_\_\_\_\_

o Urine volume (increase, decrease, normal volume per each voiding event)

o Straining or evidence of discomfort: \_\_\_\_\_\_

o Appearance (yellow, clear, discolored/red?): \_\_\_\_\_\_

o Discharge (vulva, prepuce): \_\_\_\_\_\_

o Inappropriate urination? (in the house?) \_\_\_\_\_\_

o At rest/while asleep? \_\_\_\_\_\_

o Consciously voiding on the floor? \_\_\_\_\_\_

o Dribbling without realizing it? \_\_\_\_\_\_

4) Lifestyle

o Indoor or outdoor: \_\_\_\_\_\_

o Other pets in household: \_\_\_\_\_\_

o Diet: (Brand, flavor, amount) \_\_\_\_\_\_

5) Current medications (oral, topical, supplements): \_\_\_\_\_\_

6) Prior illnesses? (and current status of these conditions) \_\_\_\_\_\_\_\_\_\_