

# Madison Veterinary Hospital P.A.

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## SENIOR CARE WELLNESS HISTORY FORM

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

Client Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Species: Canine Feline \* Breed: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Please complete as much as possible of this history sheet, and bring it in to the hospital on the day your pet is scheduled to have its Senior Comprehensive Medical Workup. You will not see the doctor at the morning admission, though you may provide any additional information to the admitting Veterinary Technician. When you collect your pet in the late afternoon your doctor will go over any initial findings with you, though please remember that most bloodwork results will not be available at that time, and final conclusions, treatment or dietary recommendations will be communicated with you in a later telephone call.

\* CIRCLE APPROPRIATE OPTION

Preferred Doctor to do evaluation? \_\_\_\_\_

Current Diet: \_\_\_\_\_

How much fed? \_\_\_\_\_ per day

### PHYSICAL SYMPTOMS:

Vomiting Yes/No \* How often? \_\_\_\_\_ Vomits what? \_\_\_\_\_

Diarrhea Yes/No \* How often? \_\_\_\_\_ Color? \_\_\_\_\_

Consistency? \_\_\_\_\_ Mucus present? Yes/No \* Blood present? Yes/No \*

Appetite Normal/Increased/Decreased \* Thirst Normal/Increased/Decreased \*

Breathing Normal/Excess Panting/Shallow Breaths/Poor Stamina \*

Coughing Yes/No \* Moist/Dry/Productive \* How often? \_\_\_\_\_

Sneezing Yes/No \* Productive? Yes/No \* Type of discharge? \_\_\_\_\_

Urination Normal/Increased amount/Increased frequency/Decreased amount/Decreased frequency \*

Blood in Urine? Yes/No \* Straining? Yes/No \* Accidents in house? Yes/No \*

### APPEARANCE:

Skin Normal? Yes/No \* If not, how? \_\_\_\_\_

Weight Recent loss? Yes/No \* Recent gain? Yes/No \* How Much? \_\_\_\_\_ lb

Hair Coat Normal? Yes/No \* Itching? Yes/No \* Flaky? Yes/No \*

Hair loss? Yes/No \* Odor? Yes/No \*

Ears Normal? Yes/No \* Odor? Yes/No \* Hearing OK? Yes/No \*

Eyes Normal? Yes/No \*

Discharge? Yes/No \*

Sight OK? Yes/No \*

**BEHAVIOR:**

Difficulty jumping up?	Yes/No *	Circling/repetitive movements?	Yes/No *
Difficulty climbing stairs?	Yes/No *	Fainting spells?	Yes/No *
Increased stiffness or limping?	Yes/No *	Seizures?	Yes/No *
If so which leg?_____		If so how often?_____	
Wanders aimlessly?	Yes/No *	Has tremors or shaking?	Yes/No *
Seems disoriented/confused?	Yes/No *	Gets "stuck" in corners?	Yes/No *
Stares into space/at walls?	Yes/No *	Difficulty finding right door?	Yes/No *
Doesn't respond to verbal cues?	Yes/No *	Doesn't recognize familiar people?	Yes/No *
Doesn't respond to name?	Yes/No *	Forgets reason for going outdoors?	Yes/No *
Sleeps more in the day?	Yes/No *	Sleeps less at night?	Yes/No *
Decrease in purposeful activity?	Yes/No *	Solicits less attention from family?	Yes/No *
Urinate indoors?	Yes/No *	Defecates indoors?	Yes/No *
If so how often_____ per week		If so how often_____ per week	
Signals less to go outside?	Yes/No *	Doesn't stand to be petted?	Yes/No *
Doesn't greet owner?	Yes/No *	Excessive barking/meowing?	Yes/No *

**OTHER SYMPTOMS:**

If there is anything else we should know, please write below:

**CURRENT MEDICATION:**

Please note all current medication, dosage and frequency:

**MASSSES, LUMPS, GROWTHS, SKIN LESIONS:**

If you have noticed any which you would like us to check, please describe in detail below:

Thankyou for completing this health questionnaire. Your answers are very important in focusing our attention on the areas in which your pet might need help. The following package of services will be completed today:

**Complete Physical Exam**  
**Superchemistry Blood Panel**  
**Blood Pressure Measurement**  
**Thyroid Screen**  
**Chest X-Rays**

**Dietary Counseling**  
**Complete Blood Count**  
**Urine sampling & Urinalysis**  
**Dental Evaluation**  
**+/- ECG**