



PATIENT INFORMATION

Cat's Name: _____ Sex: _____ Neutered? _____

Date of Birth: _____ Breed: _____ Color: _____ Declawed? _____

Please give us the approximate dates your cat last had the following:

Distemper Vaccine: _____ Feline Leukemia Test: _____

Peritonitis (FIP) Vaccine: _____ Leukemia Vaccine: _____

Rabies Vaccine: _____ Dentistry (Teeth Cleaning): _____

Who was your prior veterinarian or clinic? _____ City/State: _____

What do you usually feed your cat (brand/flavor)? _____

Does your cat ever go outside (even occasionally)? No Yes _____

Does your cat have any chronic medical problems? No Yes _____

Does your cat take medications routinely? No Yes _____

Does your cat have any adverse reactions to medications? No Yes _____

CLIENT INFORMATION Please indicate if you are a: Current Client New Client

Your Name: _____ Alternate Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Phone: Cell # _____ Work # _____ Home # _____

Alternate Contact Cell # _____ Alternate Contact Work # _____

E-mail Address: _____

Your Occupation: _____ Employer: _____

Alternate Contact Occupation: _____ Employer: _____

Emergency Contact (other than yourself): _____ Phone # _____

GENERAL INFORMATION

Do you have other pets? (please list): No Yes _____

How did you first hear of us? Sign Yellow Pages Internet/Website Humane Society Newspaper Article
(Please check only one)

Referred by _____ Other _____

What aspect of your cat's medical care is most important to you? (please only check one)

Quality Convenience Cost Comfort Other _____