



Appointment Questionnaire

Patient Name: _____ Appointment Date: _____ Appointment Time: _____

Owner Name: _____ Contact Number during appointment: _____

- 1) Has your pet received care from another veterinary facility? YES NO

If yes, please have medical records sent to us in advance of the appointment via email:

info@palisadesvetclinic.com or fax: 202-363-0615

- 2) Is your pet overly nervous/ anxious at the vet? YES NO Please note any sensitivities: _____

If yes, has your pet been dispensed medication for this issue? YES NO

- 3) What are your primary concerns for your visit? *(Note: If your pet has a growth please be specific regarding the location or mark the area with a marker in advance)*

**If you need additional room please use the notes area listed below.*

- 4) If your pet is being seen for a "Senior Wellness Visit" please answer the following:

a. Are you interested in having senior lab work done today? YES NO *(Recommended twice a year)*

b. Have you noticed any changes in your pet's mobility? YES NO

If yes, please describe _____

c. Any changes in your pet's water intake or urination frequency? YES NO

If yes, please describe _____

- 5) Is your pet currently on medications? YES NO

If yes, please list the medications along with dose and frequency: _____

- 6) Does your pet have any chronic medical conditions? *(examples: asthma, heart disease, environmental allergies, kidney or liver disease, knee surgery/ligament tear)* YES NO

If yes, please list the conditions: _____



Appointment Questionnaire

7) Do you need refills of flea/tick and or heartworm preventatives? (*Heartgard, Nexgard, Simparica, Revolution*)

YES NO

8) What is the name of the food you are currently feeding your Pet? _____

Is the food canned or dry? _____

How much/often do you feed your pet? _____

9) Does your pet need any medication or prescription diet refills? YES NO

If yes, please list the medication and current instructions _____

10) If your pet has vaccines that will be due inside the next 8 week would you like those updated today? YES NO
(Adult patients only)

11) Have you been exposed in the past 14 days to anyone with COVID-19 or showing symptoms of COVID-19?

YES NO *If yes, please contact the clinic for further instructions.*

Notes: