

Pet Name: _____ Client Name: _____ Date: _____

Senior Wellness Questionnaire

To help us assess your pet, please circle all those that apply

Eyes:

Vision ability	Normal	Decreased/Blind
Eyes	Normal	Discharge/Reddened

Ears:

Redness	No	Yes
Discharge/Dirt	No	Yes
Odor	No	Yes

Nose:

Breathing Changes	No	Cough/Sneeze/Panting
Nasal Discharge	No	Yes

Mouth:

Bark (Voice) Changes	No	Yes
Poor Breath (Halitosis)	No	Yes

Elimination:

Urination	Normal	Increased/Decreased
Difficulty Urinating	No	Yes
Defecation	Normal	Diarrhea/Constipation
Difficulty Defecating	No	Yes
Loss of Houstraining	No	Yes
Incontinence	No	Yes

Nutrition:

Appetite	Normal	Increased/Decreased
Thirst	Normal	Increased/Decreased
Weight Change	No	Increases/Decreased

Physical:

Tumors/Growths	Absent	Present
Skin/Hair Coat Changes	No	Yes
Difficulty Climbing Stairs	No	Yes
Difficulty Jumping Up	No	Yes
Increased Stiffness or Limping	No	Yes
Limb weakness	No	Yes
Seizures	No	Yes
Tremors/Shaking	No	Yes

Behavior:

Barking frequency	Normal	Yes/Increased/Decreased
Change in Activity Level	No	Yes
Confusion or Disorientation	No	Yes
Less interaction with Family	No	Yes
Changes in Sleeping Patterns	No	Yes/Increased/Restlessness
Decreased Responsiveness	No	Yes

Please answer a few more questions on the backside of this form.

Circle any oral or topical treatments your pet has received in the past 12 months:

antihistamines,	heartworm preventative,	vit E, vit C
aspirin,	hairball treatments,	
dewormers	herbs/natural remedies,	
flea treatment,	medicated shampoo,	
glucosamine,	Pet Tabs,	

Please list additional medication/supplements: _____

List any previous significant health history (injury, seizures, diabetes, etc.) _____

Nutritional Diet:

Food: _____

Amount per feeding: _____

How many times a day? _____

Does your pet receive Table Food? Yes No What? _____

Treats (biscuits, rawhides, etc.) _____

Additional concerns and comments:

(Please Explain) _____

