

					Pre-Examination History Checklist				
Patient:		Owner's Name:			Age:		Date:		
		None	Mild	Mod.	Severe	Date Began		N/A	
Weight Gain ____ Weight Loss ____									
Appetite Increase ____ Decrease ____									
Constipation / Difficult Defecation ____									
Increased Drinking ____ Increased Urination ____									
Coughing ____ Weakness After Exercise ____									
Increased Panting ____ Sneezing ____									
Lumps/Bumps ____ Skin Problem ____									
Describe:									
Bad Breath /Sore Gums/ Difficulty Chewing ____									
Housesoiling: Incontinence (dribbling Urine) ____									
Bowel Movements ____ Marking/Spraying ____									
Describe:									
Decreased Awareness, gets confused/Lost ____									
Decreased Recognition of Family ____ Learned Commands ____									
Describe:									
Decreased Affection/Interaction with family ____									
Increased Irritability, Aggression ____									
Increased Fear, Anxiety ____									
Decreased Tolerance Of Handling ____									
Decreased Hearing or "Selective" Hearing ____									
Repetitive Behaviors: pacing ____									
Overgrooming ____ Lack of grooming ____									
Licking non-food items ____									
Describe:									
Muscle Tremors/Shaking ____									
Weakness/Incoordination ____									
Difficulty Climbing Stairs/Increased Stiffness ____									
Decreased Activity/Sleeps more ____									
Excessive Vocalization: Day ____ Night ____									
Waking Family At Night ____									
Any Other Problems/Concerns Not Mentioned:									
Current Medications:									
Nutritional Supplements:									
Diet:									
Previously Diagnosed Medical Problems:									
Thank-you, Dr. Greenfield, Dr. Alario and Dr. Gothelf									