Patient Questionnaire for Ears

1) If your pet's history (i.e. vaccines etc.) is not with us, which hospital should we contact?

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2) Does your pet spend any time outdoors? ( ) Yes ( ) No what percent each day? _______________
( ) Fenced yard ( ) Leash walk ( ) Free roam

3) What is your pet's diet? ___________________________________ How much? _____________________________

4) Does your pet receive any medications or supplements? (Prescribed or OTC) ( ) Yes ( ) No

If yes, what medication and how much? ____

Heartworm Prevention _____________________________________ Date of last dose __________________

Flea/Tick Prevention _______________________________________ Date of last dose _________________

5) Habits / Symptoms

Urination:	( ) Normal	( ) Increased	( ) Decreased
Defecation:	( ) Normal	( ) Increased	( ) Decreased
Eating:	( ) Normal	( ) Increased	( ) Decreased
Drinking:	( ) Normal	( ) Increased	( ) Decreased
Vomiting:		( ) Yes	( ) No
Diarrhea:		( ) Yes	( ) No
Coughing:		( ) Yes	( ) No
Sneezing:		( ) Yes	( ) No
Scratching/Chewing/Licking:	( ) Yes	( ) No	Where? _______________

Is your pet shaking his/her head? ( ) Yes ( ) No
Scratching at ears? ( ) Yes ( ) No

Describe the ears: Red ( ) Yes ( ) No Painful ( ) Yes ( ) No Irritated ( ) Yes ( ) No

Odor ( ) Yes ( ) No Discharge ( ) Yes ( ) No

Does your pet have frequent ear infections? ( ) Yes ( ) No

******In order for the doctor to determine the source of the ear infection, we will have to do ear cytology along with the examination******

PLEASE CHOOSE ONE OF THE OPTIONS BELOW AND SIGN.

I give the Doctor permission to do any additional treatment or medication administration that she may deem

necessary. ____

Please call me if the Doctor needs to do any additional treatment or medication.

_________________________________ ***Contact number*** ________________________________