

# KANSAS CITY VETERINARY CARE, L.C.

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## PLEASE COMPLETE AND BRING FOR WELLNESS EXAM

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Owner Name \_\_\_\_\_ Acct# \_\_\_\_\_

### CANINE HISTORY AND RISK FACTOR EVALUATION

For us to evaluate your dog it is very important that you are his/her voice. We'll use this information to evaluate your dog's health and individualize the care your dog receives, including vaccinations and examinations. Please answer yes or no to the following questions to describe your dog's lifestyle.

My dog:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Is taken for walks.                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is taken to parks for exercise and play              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Goes camping with us                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is taken to groomers                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Occasionally goes to Petsmart or PetCo               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is taken to the country or farm                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is taken to boarding kennels when we are on vacation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is taken to outdoor community events                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is taken to community vaccination clinics            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is sometimes visited or visits other dogs            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Attends obedience or training classes                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Participates in competitive events, i.e. dog shows   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is used for hunting                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is kept in a yard with an electric fence             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please answer the following questions to the best of your knowledge.

- |  |                                      |                                    |   |
|--|--------------------------------------|------------------------------------|---|
| Appetite   | <input type="checkbox"/> Decreased   | <input type="checkbox"/> Increased | <input type="checkbox"/> Normal   |
| Weight   | <input type="checkbox"/> Loss        | <input type="checkbox"/> Gain      | <input type="checkbox"/> Stable   |
| Water Consumption                                | <input type="checkbox"/> Decreased   | <input type="checkbox"/> Increased | <input type="checkbox"/> Normal   |
| Bowel Movements                                  | <input type="checkbox"/> Constipated | <input type="checkbox"/> Normal    | <input type="checkbox"/> Diarrhea   |
| Urination  | <input type="checkbox"/> Decreased   | <input type="checkbox"/> Normal    | <input type="checkbox"/> Increased Frequency/Amount   |
| Incontinence (Loss of Housetraining)             | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Vomiting   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Coughing   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Sneezing   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Gagging  | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Listlessness                                     | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Weakness   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Shaking Head                                     | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Scratching                                       | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        | Location _____  |
| Significant Hair Loss                            | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Flea Control Used                                | <input type="checkbox"/> Frontline   | <input type="checkbox"/> Advantage | <input type="checkbox"/> Revolution <input type="checkbox"/> Other  |
| Heartworm Control                                | <input type="checkbox"/> Heartgard   | <input type="checkbox"/> Sentinel  | <input type="checkbox"/> Interceptor <input type="checkbox"/> Other   |
| Scotting   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Unusual Lumps/Bumps                              | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Bad Breath                                       | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Unusual discharge                                | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        | Location _____  |
| Lameness   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        | Which Leg <input type="checkbox"/> RF <input type="checkbox"/> LF <input type="checkbox"/> RR <input type="checkbox"/> LR |
| Difficulty Rising                                | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Behavioral Changes                               | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Allergies/Reactions to Medication or Vaccination | <input type="checkbox"/> Yes         | <input type="checkbox"/> No        |   |
| Current Medications                              | _____                                |                                    |   |