ATRIUM
CAT HOSPITAL

Sick Visit Form

Your Name:* _____

Cat's Name:* _____

Primary Problem:* In your own words, please tell us the primary reason for this visit. (Please be as detailed as possible about any concerns.) _____

_____

_____

_____

_____

_____

When did the primary problem start?* _____

_____

Overall, the primary problem has:* Gotten better | Stayed the same | Gotten worse

Please explain. _____

_____

_____

Has your cat received any previous treatments for the primary concern (prescribed by vet, over the counter, home remedies, etc.)? Yes | No

If so, what was the response? _____

_____

_____

Changes in Health & Behavior

General Health

Change in thirst?	Increased | No change | Decreased
Change in weight?	Increased | No change | Decreased
Change in appetite?	Increased | No change | Decreased
Change in activity level?	Increased | No change | Decreased
Change in urination?	Increased | No change | Decreased
Difficulty urinating?	Yes | No | Not sure
Difficulty having a bowel movement?	Yes | No | Not sure
Diarrhea?	Yes | No | Not sure
Vomiting (including hairballs)?	Yes | No | Not sure

Mouth & Gums

Change in the odor of the breath?	Yes | No | Not sure
Change in the appearance of the teeth?	Yes | No | Not sure

Respiratory

Coughing or change in breathing?	Yes | No | Not sure
Congestion or discharge from nose/eyes?	Yes | No | Not sure

Eyes & Ears

Changes that may suggest poorer eyesight?	Yes | No | Not sure
Changes that may suggest poorer hearing?	Yes | No | Not sure

Muscles & Joints

Lameness or stiffness?	Yes | No | Not sure
Difficulty getting in/out of the litter box?	Yes | No | Not sure
Difficulty jumping?	Yes | No | Not sure
Difficulty going up or down stairs?	Yes | No | Not sure

Skin & Fur

Lumps or bumps you have noticed on the skin?	Yes | No | Not sure
Change in your cat's coat?	Yes | No | Not sure
Change in your cat's grooming behavior?	Yes | No | Not sure

Behavioral

Hiding or withdrawal?	Yes | No | Not sure
Clinging/seeking more attention?	Yes | No | Not sure
Sleeping more?	Yes | No | Not sure
Urinating or defecating outside of litter box?	Yes | No | Not sure
Confusion or disorientation?	Yes | No | Not sure
Anxiety, fear, phobias or aggression?	Yes | No | Not sure

Please add details for any abnormalities noted above. _____

_____

_____

_____

_____

_____

Your Signature* _____ Date* _____/_____/_____

**This information is required.*