Patient Recheck Assessment Form

Pet's Name: _____ **Date**: _____

Reason for today's recheck: _____

Observed improvement since last visit: ◯ EXCELLENT ◯ GOOD ◯ SOME ◯ NONE

Questions or concerns: _____

Attitude: ◯ Normal ◯ Depressed/Lethargic ◯ Disoriented

Body Weight: ◯ Stable ◯ Increased ◯ Decreased

Appetite: ◯ Normal ◯ Increased ◯ Decreased

Water Intake: ◯ Normal ◯ Increased ◯ Decreased

Urination: ◯ Normal ◯ Abnormal _____

Bowel Movements: ◯ Normal ◯ Abnormal _____

Coughing: ◯ NO ◯ YES _____

Sneezing: ◯ NO ◯ YES _____

Eye Discharge: ◯ NO ◯ YES _____

Nasal Discharge: ◯ NO ◯ YES _____

Vomiting / Regurg. ◯ NO ◯ YES _____

Other symptoms:

_____

Diet (Brand and Amount): _____ **Dry** _____ **Canned** _____

Treats (Brand and Frequency): _____ **People Food:** ◯ NO ◯ YES _____

Please list <u>ALL</u> medications including <u>supplements</u> and <u>doses</u> you are giving:

_____

_____

Medication refills needed? _____