



# West Coast Veterinary Dental Services

1350 Kootenay Street  
Vancouver, BC  
V5K 4R1

Phone: 604-473-3605 Fax: 604-473-3620

Date: \_\_\_\_\_

## PATIENT QUESTIONNAIRE

Please take a moment to answer the following questions as best as you can to help us treat \_\_\_\_\_.  
Pets Name

1. When was the last time your pet had any food? Note the type of food and the amount given.

\_\_\_\_\_

2. Has your pet received any medications or supplements before being dropped off today? If so please indicate the name of the medication and/or supplement and the dosage that was given.

DRUG _____	DOSE _____
DRUG _____	DOSE _____
DRUG _____	DOSE _____
DRUG _____	DOSE _____

3. For today's visit does your pet require any of his/her current medications? YES \_\_\_\_ NO \_\_\_\_  
If yes, please note the name of the medication, the dosage and when the treatment is due.

DRUG _____	DOSE _____	TIME _____
DRUG _____	DOSE _____	TIME _____
DRUG _____	DOSE _____	TIME _____
DRUG _____	DOSE _____	TIME _____

4. Does your pet have any allergies? If so please list them: \_\_\_\_\_

5. Does your pet require a special food while it is in hospital, due to an allergy or illness? If so please provide us with that food and record the time it is due to be given and the amount.

FOOD \_\_\_\_\_ TIME \_\_\_\_\_ AMOUNT \_\_\_\_\_

6. Was any of the following taken at your regular clinic?

Blood work \_\_\_\_ Urine \_\_\_\_ Radiographs \_\_\_\_

7. Were any medications or supplements dispensed at your regular clinic prior to your appointment at WCVDS? If so please provide the names and dosages below. Do you require a refill of any of the medications?

DRUG _____	DOSE _____	REFILL: yes ____ no ____
DRUG _____	DOSE _____	REFILL: yes ____ no ____
DRUG _____	DOSE _____	REFILL: yes ____ no ____
DRUG _____	DOSE _____	REFILL: yes ____ no ____

8. Have you noticed any changes in your pet recently?

EATING – no change – less – more      DRINKING – no change – less – more      URINATING – no change – less – more

VOMITTING – yes – no      DIARRHEA – yes – no      OVERALL ATTITUDE – poor – fair – good - excellent

9. Please note any further questions, concerns or comments that you may have for our doctors.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE SET UP A DISCHARGE TIME WITH OUR RECEPTIONIST PRIOR TO LEAVING