

# Urinary Problems

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

Patient: \_\_\_\_\_

Owner: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

Pick up time: \_\_\_\_\_

1. When did you first notice a problem? \_\_\_\_\_

2. Has the problem: **Circle one**

    Gotten better

    Gotten worse

    Stayed the same

3. What symptoms are you seeing: **Circle all that apply**

    Red urine

    Vocalizing while urinating

    Increased need to urinate

    Urinating in inappropriate places

    Increased amount of urine

    Straining to urinate

    Decreased amount of urine

    Accidents / leaking when sleeping or resting

    Increased thirst

4. Is your animal displaying any other symptoms:

    Vomiting

        YES

        NO

    How many times: \_\_\_\_\_

    Listlessness

        YES

        NO

    How long: \_\_\_\_\_

    Appetite Loss

        YES

        NO

    How long: \_\_\_\_\_

5. What does your pet eat? \_\_\_\_\_

6. Does your pet get table scraps or treats?                      YES                      NO

7. Has there been any diet changes?    YES    NO    Explain: \_\_\_\_\_

8. Has your pet had any urinary problems before?                      YES                      NO

    If yes, explain: \_\_\_\_\_

9. Is your pet on any medications? What: \_\_\_\_\_

10. If needed can we: **Circle all that apply**

    Urinalysis

    X-ray

    Sedate

    Fasted

Owners signature: \_\_\_\_\_