

All Cats Hospital, P.A.
New Patient Information

Cat's Name:	
Breed:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown
Has your cat been spayed or neutered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Color (Description):	
Date of Birth or Approximate Age:	
Is your cat: <input type="checkbox"/> Declawed on Front Feet <input type="checkbox"/> Declawed all 4 Feet <input type="checkbox"/> Not Declawed	

Medical History

Has your cat been vaccinated within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please check the vaccines given: <input type="checkbox"/> Feline distemper/upper respiratory virus <input type="checkbox"/> Rabies <input type="checkbox"/> Feline Leukemia Virus	
Has your cat ever been vaccinated against Feline Immunodeficiency Virus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your cat live: <input type="checkbox"/> Exclusively indoors, no exposure to other cats (except other household cats) <input type="checkbox"/> Lives outdoors <input type="checkbox"/> Is indoors, but does go outside unsupervised <input type="checkbox"/> Indoors only, but another cat in household goes outside <input type="checkbox"/> Indoors only, but occasionally escapes <input type="checkbox"/> Lives indoors, goes outside under direct supervision, is never alone	
Has your cat ever been tested for Feline Leukemia Virus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Sure	
Has your cat ever been tested for Feline Immunodeficiency Virus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Sure	
Previous Veterinary Hospital: If needed, may we contact them for copies of your cat's medical record? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone:
Please list any diseases, allergies, or major surgeries.	