

DIET HISTORY FORM

Date: _____

Case Number: _____

Owner Information

Name: _____

Email address: _____

Phone (home): _____

Phone (cell): _____

Best time to call: _____

Pet Information

Name: _____ Age: _____

Species: _____ Breed: _____

Gender: Male Female Neutered/spayed: Yes No

Current weight: _____ Usual weight: _____

Body condition score (1-9): _____

Evidence of muscle wasting None Mild Severe

Reason for Visit

Household Demographics

How many adults are in your household? _____

How many children are in your household, and how old are they?

Where is your pet housed? Indoors Outdoors Both

Do you have other pets? Yes No If so, please list species and specify if they live indoors or outdoors.

Feeding Management

Who typically feeds your pet? _____

When is your pet fed? _____

Stamp clinic information below:

Is food left out for your pet during the day? Yes No

Does your pet have access to other, unmonitored food sources (e.g., treats fed by neighbor, food left for outdoor cats)?

Yes No

If yes, please describe: _____

If you have more than one pet, do they have access to each other's food? Yes No If yes, please describe:

How do you store your pet's food? _____

Activity

How active is your pet?

Hyperactive Very active Average

Not very active Hardly moves

How often is your pet walked?

At least 3 times/day 1-2 times/day Once a day

Seldom Never

Do you have access to a yard? Yes No

Is it difficult to exercise your pet? Yes No

Can exercise be increased? Yes No

Has your pet participated in training? Yes No

Has your pet participated in competition? Yes No

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Behavior

How does your pet act toward food?

- Greedy Indifferent Shows avoidance

Has your pet's attitude toward food changed? If so, describe:

If you have other pets, is this pet dominant or submissive to them?

- Dominant Submissive

Has your pet recently lost or gained weight? If so, please describe:

Have there been any recent changes in activity level? _____

Have you observed any of the following:

- | | | |
|-----------------------|------------------------------|-----------------------------|
| Nausea/salivation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty chewing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Constipation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have there been any changes in urination? Yes No

Diet

For each of the following categories, list the brand names (if applicable) and amounts of all foods your pet eats daily, as well as how often each food is fed (e.g., twice a day).

Commercial foods

Commercial treats; dental hygiene products

Table foods or scraps; home-prepared foods

Dietary supplements; food used to give pills

List anything else given by mouth (e.g., medications):

Is your pet's current diet a change from its typical diet?

- Yes No

If so, please describe the change and why the diet was changed.

Are you open to making a change in your pet's diet?

- Yes No

What are your pet's food preferences? _____

What foods does your pet refuse? _____

Are there foods to which your pet is allergic? Yes No

If so, which foods? _____
