



Maturity in Motion

Questionnaire

PET'S NAME: _____

OWNER'S NAME: _____

AGE: _____ WEIGHT: _____

PHONE #: _____

THIN NORMAL OVERWEIGHT

DATE: _____

The following questionnaire is designed to help you and your veterinarian provide the best care for your mature pet

INDICATE IF YOUR PET HAS EXPERIENCED CHANGES IN:

Yes No

Drinking		<input type="checkbox"/>	<input type="checkbox"/>
Urination		<input type="checkbox"/>	<input type="checkbox"/>
Appetite		<input type="checkbox"/>	<input type="checkbox"/>
Weight		<input type="checkbox"/>	<input type="checkbox"/>
Hair Coat	Itchy, dandruff, dull, hair loss, matting	<input type="checkbox"/>	<input type="checkbox"/>
Body Odours	Bad breath, odour from ears or skin	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	Lameness, trouble with stairs, stiff, pain, spending more time lying down	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	Coughing, shortness of breath, wheezing, exercise intolerance, mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>
Digestion	Vomiting, diarrhea, constipation, hairballs	<input type="checkbox"/>	<input type="checkbox"/>
Senses	Hearing, smelling or vision loss	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour	Reduced family interaction, increased vocalization, loss of litter training	<input type="checkbox"/>	<input type="checkbox"/>
Growths	New growths, changes in previous growths	<input type="checkbox"/>	<input type="checkbox"/>