



Neurology Consultation Questionnaire

PATIENT'S NAME: _____ DATE: _____
(First and Last Name)

Please provide only a one or two word answer OR just tick the appropriate box.

	Yes	No
1. Has your pet had any known exposure to bats?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your pet ever traveled to Vancouver Island or outside BC?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your pet had any diarrhea or vomiting in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your pet had any coughing or sneezing in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your pet shown any compulsive circling?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your pet shown any compulsive pacing?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has your pet shown any change in behavior?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has your pet shown any change in temperament?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has your pet had trouble recognizing someone familiar?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has your pet started urinating in inappropriate places?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has your pet started defecating in inappropriate places?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has your pet been staring vacantly at the walls?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has your pet been pressing his or her head into a corner?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has your pet been bumping into things as if they could not see?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has your pet had any seizures?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has your pet had any collapsing episodes?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has your pet had any loss of balance?	<input type="checkbox"/>	<input type="checkbox"/>
18. Is your pet taking any medications at the moment?	<input type="checkbox"/>	<input type="checkbox"/>
19. Is your pet eating and drinking normally?	<input type="checkbox"/>	<input type="checkbox"/>
20. Has your pet had any other major illnesses or injuries?	<input type="checkbox"/>	<input type="checkbox"/>

If so, please specify _____

21. How old was your pet when you first acquired him or her? _____

22. When was he or she last normal? _____

23. What was the first sign that you noted? _____

24. Do you have any other comments? _____