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Neurology Recheck Form

Please take a moment to answer the following questions as best as you can to help us treat your pet.

OWNER NAME: First: _____ **Last:** _____

PET'S NAME: _____

1. **List all drugs and/or medications that you give your pet. Please include the dose and frequency as the Neurologist needs to confirm this information with you for every appointment/assessment.**

Medication(s)	Dose (ie. mg or ml)	Frequency (Times Given) (ie. once a day, etc.	Last Dose Given

(If more space is needed please include in 'Additional Comments' section on next page)

Food: _____ Amount: _____ Frequency: _____ Last Ate: _____

2. **Do you require any refills of your pet's medication?** ☐ Yes ☐ No

If yes, which medication(s)? _____

3. **Has your pet visited their family veterinarian since we last saw you?** ☐ Yes ☐ No

If yes, for what reason(s)? _____

   a. **Were any of the following performed?** ☐ Blood-work ☐ Urine ☐ X-Rays

   b. **List name and dose of any medications dispensed or given:**

4. Since your pet's last visit, please comment on the following:

a. **Appetite:** ☐ No Change ☐ Increased ☐ Decreased Duration of Change _____

b. **Drinking:** ☐ No Change ☐ Increased ☐ Decreased Duration of Change _____

c. **Urination:** ☐ No Change ☐ Increased ☐ Decreased Duration of Change _____

d. **Vomiting:** ☐ No ☐ Yes How Often? _____

e. **Diarrhea:** ☐ No ☐ Yes How Often? _____

f. **Quality of Life:** ☐ Unchanged ☐ Increased ☐ Decreased (Please describe in detail below)

g. **Overall Attitude:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor (Please describe in detail below)

5. Please describe additional comments/concerns/questions you may have:

Completed by: _____

Signed: _____ Date: _____