All Feline Hospital

Urine Questionnaire

Owner Name: _____ Phone: _____
Cat's Name: _____ Age: _____
Male/Female Longhair/shorthair Date: _____

GENERAL:

1. How long has this been a problem? _____
   _____
2. Is the cat spraying or squatting? _____
3. Where are the accidents occurring? _____
4. Has the cat had this problem before? Yes/No. If yes, when, and what were the treatments?
   _____
   _____
5. What items does the cat urinate on? _____
6. Are there any new stressors for the cat? (Anything new in the house or out of place?) ___
   _____
7. Does the cat have bowel movements outside of the box? _____
8. Can the cat see outside? _____
9. How many cats are there in the household? _____
10. Is this cat (with current problem) dominant or weaker in the crowd? _____
    _____
11. How long have you owned this cat? _____
12. When was this sample collected? _____
13. Was it refrigerated? _____

LITTER:

1. What type of litter do you use? _____ Brand? _____
2. Is the litter scented or un-scented? _____
3. Has the brand of litter changed recently? _____
4. How deep is the litter? _____

LITTER BOX:

1. What type of litter box do you use? (Hood or No Hood, etc.) _____
2. Number of litter boxes in the household? _____
3. Where are the litter boxes located? _____
4. How many times a day are litter boxes cleaned? _____
5. How many times a week do you change the litter box? _____
6. Have you moved the box lately? _____
7. Are there any cleaners used on the litter box? Yes/No. If yes, what are they? _____
   _____
8. Do you use plastic liners? _____
9. How large is the litter box? _____

FOOD:

1. What brand of food do you feed? _____
2. Do you feed canned, dry, or both? _____
3. Have you changed diets recently? If so, how long ago, and what were you feeding previously?
   _____