Animal Dental Clinic of Pittsburgh, LLC

DATE:___________

Dental Questionnaire

1. Patient's Name: ______________________Owner's Name: ________________________________

2. Animal's Age:_______________ (circle) Canine or Feline. Breed:____________________________

3. Spayed or Neutered? (Circle if yes). If Intact male or female, is this a show pet? Circle: YES or NO
   If this is a show dog or cat, do you prefer the dental department to: (circle option below)
   a) SHAVE OR b) DO NOT SHAVE
   for the Intra-Venous (IV) catheter and anesthesia monitoring equipment?
   NOTE: By requesting the no-shave option for show animals, I accept the increased risk of infection at the IV catheter sited and more limited anesthesia monitoring capabilities.
   (owner's initials) ___________________.

4. Has your pet had any prior dental procedures? Circle: YES or NO. If yes, date/s:________________

   If any complications, please describe: ____

5. Has your pet had any previous episodes of general anesthesia? Circle: YES or NO

   If any complications, please describe: ____

6. Diet: Dry food, brand:____
   Wet food, brand:____
   Treats/Other:____

Is your pet having difficulty eating? Circle: YES or NO. If YES, describe the problem/s: _________________

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7. Does your pet play with any toys? If yes, describe type: _____________________________________

8. Does your pet chew on hard objects? If yes, list type: ______________________________________

9. Are you currently using any dental homecare products on your pet? Circle: YES or NO

   If yes, please list: ____

10. Is your pet currently on any medication? Circle: YES or NO. If yes, please list all medications:

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Please note any other pertinent issues or information here:

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