History Questionnaire for Norwich Terriers

Dog/client ID: ___________________________ Date: ____________

Circle appropriate response:

1. Does your dog have increased respiratory noise?    No   Yes

2. What is your dog’s main breathing problem? Loud Raspy Gurgly Excessive panting Coughing Gagging None Other ___________________________

3. Are signs worse during: Exercise Excitement or stress Hot weather Humid weather

4. Has your dog ever collapsed, gasping for air? Yes No Not sure

5. How frequently does your dog make respiratory noises when awake?

Never Occasionally Intermittently Frequently All the time

Never Occasionally Intermittently Frequently All the time

Sever al times a month Several times a week Every day Many times during the day

6. Does your dog snore when asleep?

Never Occasionally Intermittently Frequently All the time

Never Occasionally Intermittently Frequently All the time

Several times a month Several times a week Every day Many times during the day

7. When did respiratory signs start?  < 1yr of age 1-2 yrs of age 3-4 yrs of age 5-6 yrs of age older Not sure

8. Have you seen a decrease in exercise tolerance since the clinical signs started? Yes No Not sure

a. If yes, how would you rate this:

1: runs around, but has to sit 2: walks well, but has to sit 3: short walks, but pants heavily 4: will collapse on walks 5: cannot exercise at all

9. Does your dog have an unusual bark? Yes No Not sure

a. If yes, describe: ___________________________

10. Has your dog undergone any previous surgery to its upper airway or neck? Yes No

a. If yes, describe: Nostrils Tonsils Saccules Soft palate Other (describe): ___________________________

11. Does your dog have trouble with: Eating Drinking Regurgitation or vomiting None

12. Other Information: Does your dog have a history of (check all that apply):

<table>
<thead>
<tr>
<th>Tonsillitis</th>
<th>Allergies</th>
<th>Runny eyes</th>
<th>Runny nose</th>
<th>Periodontal disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheal collapse</td>
<td>Seizures</td>
<td>Something stuck in nose</td>
<td>Heart Disease</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Pulmonary fibrosis</td>
<td>Cleft palate</td>
<td>Difficulty sleeping</td>
<td>Obesity</td>
<td>Megaesophagus</td>
</tr>
</tbody>
</table>

Additional history: ___________________________

Current Medications / Supplements: ___________________________

Owner  Date  Clinician  Date