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** (Several times a month) **Intermittently** (Several times a week) **Frequently** (Every day) **All the time** (Many times during the day)
6. Does your dog snore when asleep?
   Never **Occasionally** (Several times a month) **Intermittently** (Several times a week) **Frequently** (Every day) **All the time** (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** **2** **3** **4** **5**
   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):

Tonsillitis	Allergies	Runny eyes	Runny nose	Periodontal disease
Tracheal collapse	Seizures	Something stuck in nose	Heart Disease	Pneumonia
Pulmonary fibrosis	Cleft palate	Difficulty sleeping	Obesity	Megaesophagus

Additional history: _____

Current Medications / Supplements: _____

Owner _____ Date _____ Clinician _____ Date _____