

Feline behavior consultation questionnaire

General Information

Today's date: _____ Date and time of consultation (if scheduled): _____
 Name: _____
 Address: _____ City/Town: _____ Postal (Zip) Code: _____
 Phone: Home: _____ Business: _____ ext: _____ Mobile/other: _____
 FAX: _____ Email: _____
 Veterinary Clinic: _____ Veterinarian's Name: _____
 Clinic phone: _____ Who referred you to our service? _____

Pet Information

Pet's Name: _____ Date of birth: _____ or Estimate age: _____ Years or _____ Months
 Weight: _____ kg _____ lb Sex: Male Female Neutered: Yes No At what age?
 Any change after neutering? Yes No If yes, describe:
 Breed: _____ Color: _____
 Declawed: Yes No If yes, at what age? _____ Describe any changes noted after declaw?

Your pet's early history

Age obtained: _____ From where did you obtain this pet?
 Name of Breeder / Shelter:
 Describe previous home (if known) including litter size, how raised, age weaned, other pets, family:
 Describe (if known) how much interaction your cat has had with people or other pets before it was obtained
 Behavior of parents or littermates (if known):
 For what reason did you obtain this cat? (check all that apply): companion for family ; companion for cat ;
 rodent control ; breeding/show ; other
 Describe your cat's personality (check all that apply): friendly ; bold ; over-active ; playful ;
 demanding attention ; independent ; fearful / nervous ; aggressive ; noisy/vocal ; excitable ; depressed ;
 other

The Home Environment

List each family member living in the home (include age of children):

Name	Age	Occupation

Describe how your pet gets along with each family member including any problems:

List all other pets in the home:

Name	Species	Breed	Sex	Age	Relationship

Describe if any of the pets do not get along with each other:

Your Cat's Activities

Diet and nutrition

Type of food: when do you feed / feeding routine:

What food does your cat prefer?

Describe your pet's appetite: Voracious Good Average Picky Poor Variable

Do you give treats Yes No Type of treats?

What treats does your cat prefer?

Describe your pet's interest / appetite for treats: Voracious Good Average Picky Poor Variable

When and how often do you give treats?

List any food supplements or additives:

Does your cat hunt? Yes No If yes, describe when and how often:

What is your cat's favored prey?

Does your cat eat the prey?

The Home Environment

Describe you and your cat's daily schedule:

Does your cat spend time outdoors? Yes No If yes, confined to the yard on harness free to roam cat door

If outdoors, describe when, where and how often

Does your cat see, hear or come in contact with outdoor cats? Yes No If yes, describe:

Have you used a crate for housing or travel Yes No If yes, describe cat's reaction:

Where is your cat's favorite sleeping spot / resting area / bed during the night?

Where is your cat's favorite sleeping / resting / bed / perching area during the day?

Does your cat have a favored climbing / perching area / play centre? Yes No If yes describe

Does your cat climb / perch / play in areas that are undesirable to you? Yes No If yes describe

Does your cat have a scratching area / preferred scratching location? Yes No If yes, describe

Does your cat scratch in areas that are undesirable? Yes No **If yes continue: If no proceed to Cat's Environment:**

List undesirable locations?

When and how often does your cat scratch these locations?

Are there specific events that precede scratching?

Do see your cat scratching?

If yes, what do you do:

Cat's reaction:

What do you do when you find an area that your cat has scratched?

Cat's reaction:

What have tried so far to treat the scratching and what, if anything has been effective?

Cat's Environment - Please bring pictures or video of your home including where problems occur.

Describe home: Detached family home ; Town (row) house / semi-detached Apartment / high rise rental
Condo / high rise owned Rented room / basement Trailer home Other Describe:

How many stories? How many rooms?

Please draw a diagram of each floor of your home and scan or FAX. (Use additional pages for other floors)

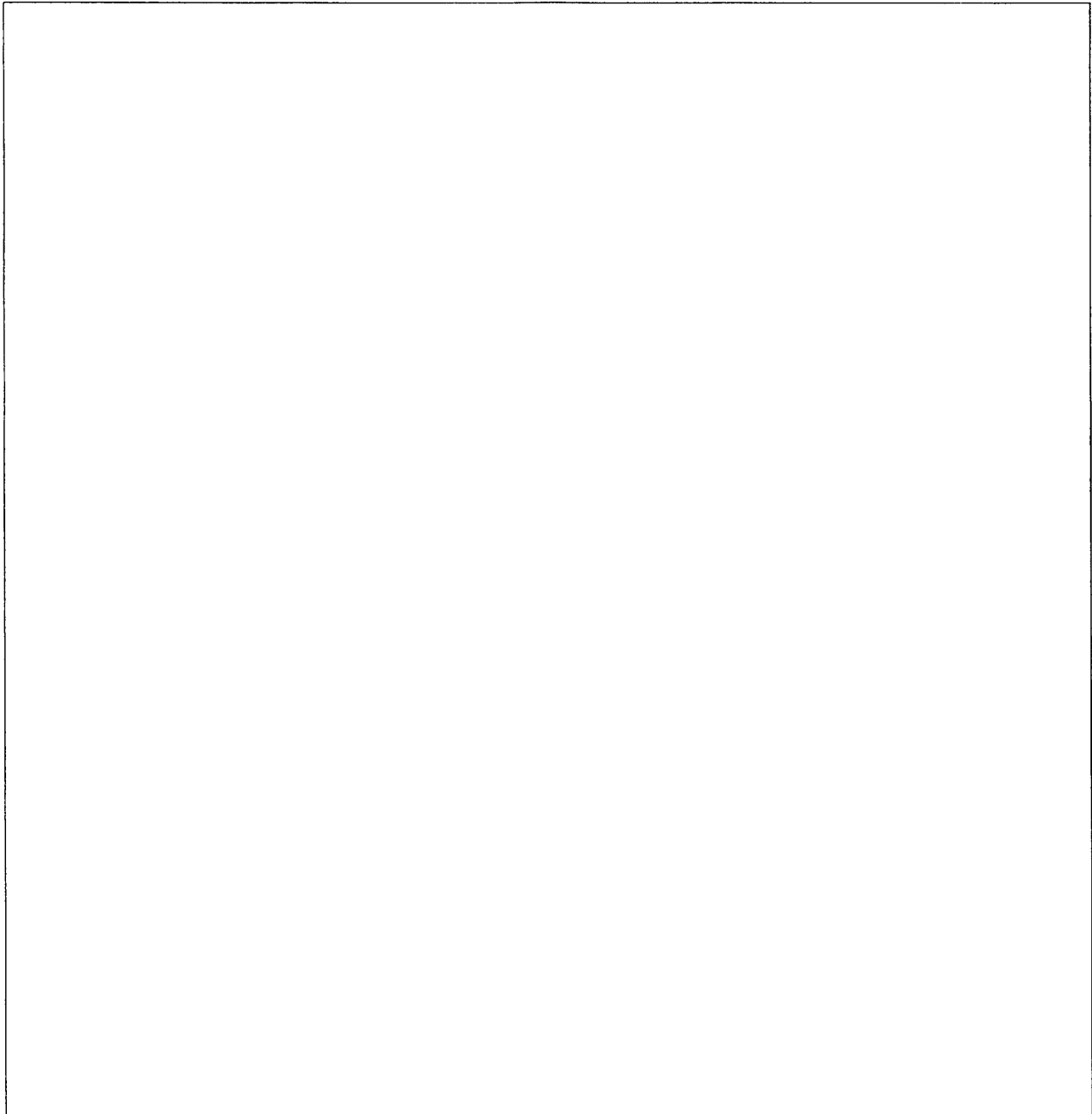
Label each room. Identify windows and doors. Identify any large furniture. Also indicate type of floor for any areas soiled.

Use the codes below to label litter box locations, feeding areas, play stations, resting areas, and problems

L: Litter – please number each location e.g. **L1, L2, L3 etc.**) - **F:** feeding location: - **P** - play area / play center:

SP: for Scratching post – **SD:** Sleep / resting locations (day) – **SN:** Sleeping locations (night) **W:** Window

Problems: **U:** site of urine soiling - **M:** site of urine marking (upright surfaces) – **BM:** site of stool soiling - **S:** site of destructive scratching



Principle Complaint

The following questions are required to assess your pet's problem. It is not necessary to duplicate answers from previous sections or in future sections. Please consider bringing movie clips or pictures of the problem behaviors and the cat's environment.

List all Problems that need to be addressed Begin with your primary complaint	Age problem began	Very Serious	Fairly Serious	Not Serious

Have you considered removing your cat from the home if the problem cannot be improved? Yes No

Comment:

What are your goals for this consultation?

For the primary problem(s) what age was your cat when the problem started?

Describe any changes in the home or the pet's health when the problem first started:

What do you think caused the problem?

Describe the problem, beginning with the most recent incident?

Describe the first incident and any other pertinent incidents:

How often does the problem occur?

Has there been a recent change in frequency or severity? Yes No If yes, describe:

List each behavioral treatment you have tried (other than drugs), and the cat's response:

Date/when	Treatment	Cat's Response / Outcome

Which approach has been most successful (if any):

List any techniques that have made the problem worse:

List any medications, supplements or remedies tried so far, and the cat's response (effects, side effects):

Date	Medication (when started, dose, frequency, duration)	Outcome (effects, side effects, is pet still receiving)

Training

Have you or your cat had any formal training? Yes No If yes, did your cat attend kitten classes? Other training?
 In home instruction? Other If yes describe:

Have you done any of your own training with your cat? Yes No If yes, describe:

What sources (books, DVD, websites) have you used for advice on cat behavior and training if any?

Does your cat respond to any commands / cues? Yes No If yes, check all that apply: Sit: Down: Come:
 Go to e.g. bed / room: Other trained commands:

Who does your cat respond to the best?

List any tricks your cat can perform:

Describe your cat's learning ability:

If you wanted to get your cats attention or get your cat to come what would work best (e.g. shaking a box of treats, command)?

How successful would this be? Very ; Most times ; Occasional ; Unsuccessful ; Other:

List your cat's top 3 food or treat rewards:

List your cat's top 3 non-food rewards (e.g. toy, affection):

Have you used any of the following for training :

	No	Yes	No Effect	Worsens	Effective	Comments / describe success
Positive reinforcement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lure / reward training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food / treat rewards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toy / play reward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Affection / reward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clicker training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assertive / confront	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Body harness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Collar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Punishment / Discipline / Corrections used

	No	Yes	No Effect	Worsens	Effective	Comments/describe
Verbal reprimand - no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical punish - hit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Scruff / neck grasp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical lift / pin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shake can / noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ultrasonic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Water spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Air or citronella spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Booby trap / repellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Time-out / confinement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Have you used any other punishment not listed above? Yes No If yes, describe:

What punishment is most effective?

Has punishment made the problem worse or resulted in aggression? Yes No If yes, describe which:

Does your cat respond differently to punishment from different family members? Yes No If yes, describe:

Play and activities

Interactive / Social play

Do you play with your cat? Yes No If yes, what is favored game:

Describe when, how often, with whom:

Object / exploratory play

Does your cat engage in play on its own? Yes No If yes, what are favored toys / activities:

Describe when and how often:

Does your cat have an activity center? Yes No If yes, what are favored toys / activities:

Please indicate your cat's interest in the following activities

Level of interest	High	Low	None	How often	Describe / Favorite
Chase toys with owner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Self play – batting toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Self play – run / chase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Food filled toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Exploring e.g. bags, box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fetch / chase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chewing / cat grass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Laser toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Catnip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Climb / Perch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Scratch posts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Going outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Does your cat engage in over-exuberant or unacceptable play?

Does your cat chew on or swallow objects that are inappropriate / undesirable?

Describe any of these problems in greater detail:

Is there anything not listed previously that might cause your cat to become fearful, anxious or aroused: Yes No If yes describe

Describe your cat's level of arousal in these situations: Mild ; Moderate ; High / Excessive
How long after exposure to these events has passed, does it take for your cat to settle down (i.e. back to normal)

Are there any problems when travelling? Yes No If yes, describe:

What do you do to try and correct the problem?

Cat's reaction:

Describe how you transport your cat? Carried by family member On seat Carrier Other:

AGGRESSION: Does your cat ever display aggression to people or other animals? Yes No
If no please proceed to next section – elimination. If yes, please continue:

Is aggression the primary reason for today's visit? Yes No Describe severity? Mild ; Moderate ; Severe
Please indicate to which of the following your cat has shown aggression: Family members ; visitors ; familiar cats in home ; unfamiliar cats in the home ; outdoor cats ; dogs in home ; other animals ; veterinary visits ; groomer ; Other:

Does the aggression occur when owners are: present ; absent ; both ; Comment:

Have you considered removing your pet from the home if the problem cannot be improved? Yes No If yes, comment:

In what situations does your cat display aggression?

How often has the problem occurred? Is the problem a) getting better ; b) staying the same c) getting worse
Describe the aggression: Threats no bite Bites but not break skin Bite with minor injury Serious injury
Other:

Describe your cats demeanour at the time of aggression: Playful ; Fearful ; Bold / Assertive ; Other

Describe the most recent event: What happened immediately prior to the event?

Describe the event

Describe your cat's appearance (body posture, face, ears, tail, hair on back)

What did you do at the time?

What was your cat's reaction?

Has any treatment used to date been effective? Yes No If yes, describe:

Has any treatment made the problem worse? Yes No If yes, describe:

Elimination & Litter Information:

How often do the following events occur?	Many times a day	Once Daily	Weekly	Every 2 weeks	Monthly	Never	Other	Comments / describe
Cat urinates in litter box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cat urinates outside box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cat sprays urine / marks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cat defecates in litter box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cat defecates outside box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cat eliminates outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Litter box is scooped out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Litter replaced with new litter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Litter box cleaned and washed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Litter location - indicate what preferred by each cat	Type of litter	Type of box
1.		
2.		
3.		
4.		
5.		

Does your cat ever use its litter box while you are watching? Yes No

Indicate which box(es) your cat prefers:

Indicate which box(es) your cat seldom or never uses:

Indicate which litter your cat prefers:

Indicate which litter your cat seldom uses or avoids:

Does your cat dig / bury before or after eliminating? Yes No If yes, describe:

Indicate any differences between your cats as to their preferred litter or box:

Elimination Problems - Does your cat have a problem with housesoiling or marking)? Yes No
If NO, proceed to fear and anxiety. If yes, please continue:

Is elimination the primary reason for today's visit? Yes No Is the problem: getting worse ; staying same ; improving

Is the urine soiling a) stools b) urine: c) both Is the soiling a) only on horizontal surfaces (floors) b) only on vertical (upright) c) mostly upright and some horizontal d) mostly horizontal and some upright e) both upright and horizontal

Stool: At the time the problem began describe your pet's stool: Normal ; Constipation ; Less frequent ; More frequent ; Soft/diarrhea ; Blood/mucous Straining/discomfort ; Vocalization If any change from normal describe:

Are there any ongoing abnormalities? Yes No If yes, describe:

Urine: At the time the problem began describe your pet's urine: Normal ; Less frequent ; More frequent ; More volume /amount ; Less volume ; Straining / discomfort ; Vocalization Blood If any change from normal describe:

Are there any ongoing abnormalities? Yes No If yes describe:

Has there been any change in appetite? Yes No If yes, describe:

Has there been any change in drinking? Yes No If yes, describe:

Was your pet ever completely "litter trained"? Yes No If yes, describe:

Inappropriate Locations soiled	Surface	Urine, stool or both	When / How often?
		Stool <input type="checkbox"/> Urine <input type="checkbox"/>	
		Urine <input type="checkbox"/> Stool <input type="checkbox"/>	
		Urine <input type="checkbox"/> Stool <input type="checkbox"/>	
		Urine <input type="checkbox"/> Stool <input type="checkbox"/>	
		Urine <input type="checkbox"/> Stool <input type="checkbox"/>	

When your cat is indoors a) what percentage of urine is outside of the box?

b) what percent of stool is outside box

Is there a particular surface / texture on which your cat prefers to soil? Yes No If yes describe

Are there any surface types where your cat never soils? Yes No If yes describe

Is there a room or location where your cat prefers to soil? Yes No If yes describe

Is there a room or location where your cat never soils? Yes No If yes describe

Is there a time of day when the problem is most likely to arise?

Can you think of any pattern when the problem is most likely to arise?

Have seen your cat when it is soiling? Yes No If yes describe

If yes what do you do

Cat's reaction?

List types of litter that you have tried?	Indicate cat's response:
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>

What is your cat's favorite litter?

List types of boxes that you have tried?	Indicate cat's response:
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>
	Uses readily <input type="checkbox"/> Uses but not a favorite <input type="checkbox"/> Avoids <input type="checkbox"/>

What is your cat's favorite box?

Have you tried litter with deodorizer? Yes No If yes, describe:

Have you tried different depths of litter? Yes No If yes, describe:

What age was your pet when this problem started?

Describe the first incident:

Were there any changes in the household or litter when the problem began?

What do you think caused the problem?

What has been done so far (other than drugs) to try and correct the problem and how did the cat respond?

List any techniques that have been successful:

List any techniques that have made the problem worse:

List any drugs or pheromones tried so far and the cat's response to the medication (efficacy, side effects):

Grooming

Does your cat's self grooming appear to be: Normal Excessive Decreased

When is your cat most likely to groom?

Describe situations or events that lead to increased grooming:

Describe situations or events that lead to decreased grooming:

Does your cat lick or groom: Self Other cats in home People in Home Household objects If yes, describe:

Are any of these behaviors excessive or problematic? Yes No If yes, please describe:

Does your cat knead? If yes, please describe when and with whom:

Do you feel your cat's kneading is unusual or excessive? If yes, please describe:

If this is the primary reason for today's visit, please provide more details in the Primary Complaint Section:

Feline skin disorders

Does your cat have problems with overgrooming, rippling skin, excessive scratching or hair loss? Yes No

If NO please proceed to next section – Primary Complaint. If yes, please continue:

Is a skin disorder the reason for today's visit? Yes No Is the problem: getting better ; staying the same improving

Describe the problem:

When did the problem first begin? (cat's age, time of year, etc.)

Do any pets in your home go outdoors? Yes No If yes, which ones?

Were there changes in the household, which may have occurred just before the problem began?

Were there changes in the cat's health or behavior when the problem began?

Has the severity, frequency, pattern or type of hair loss changed since the problem first arose? Yes No If yes, please describe:

Is there a particular event that is most likely to cause or aggravate the problem?

Is there a particular time of month or time of year that the problem gets worse or begins to improve?

Is the behavior more likely to occur when you are: At home but out of the room ; at home in the room ; away from home

Do any other pets in the household have any skin problems? Yes No If yes, please describe:

Have any other family members or friends developed skin problems? Yes No If yes, please describe:

What has been done so far to try and correct the problem?

What was the cat's response?

List any techniques or medications that have been at all successful:

List any techniques or medications that have made the problem worse:

List any drugs tried so far, and the cat's response to medication (improvement / side effects):

Miscellaneous

	Never	Occurs but not a concern	Occurs Would like to improve	Comments/describe
Jumps on counters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
On furniture where not allowed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In rooms where not permitted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nips / grabs – play bite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Altered Sleep – night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperactive / over-exuberant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hiding / avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Not social – avoids affection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vocalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Licking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tail chasing / attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sucking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Light chasing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Snaps at air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperesthesia (rippling skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Roaming / running away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mounting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other – Describe any problems not previously listed:

Medical Screen

Please have your veterinarian complete medical history and submit most recent diagnostic (lab) tests.

When was your cat's last veterinary visit?

Reason for visit:

Are vaccines up to date? Yes No If no, describe:

Does your pet have any ongoing medical problems? Yes No If yes, describe:

Is your pet presently on any medication? Yes No If yes, describe (include name, dosage, duration):

Has your pet had any laboratory tests? Yes No When: What tests?

If yes, indicate any abnormal findings:

Change in appetite: Yes No If yes, describe:

Change in weight: Yes No if yes, describe:

Does your pet drink excessively? Yes No If Yes, describe (how often, how much):

Does your pet have arthritis or any other painful condition? Yes No If yes, describe condition and treatment:

Have you noticed any deficits in your pet's senses? Yes No If yes, describe:

Have you noticed any change in stool frequency (how often) or in the way it looks Yes No If yes, describe:

Have you noticed any change in the frequency of urination or any discomfort? Yes No If yes, describe:

Have you notice any other health issues: Yes No If yes, describe: