UPPER AIRWAY HISTORY QUESTIONNAIRE

ALL ABOUT GOLPP

1. When did you first notice any problem with your dog's breathing? _____

2. How old was your dog at this time? _____

3. What did you first notice? _____

_____

_____

4. Has your dog shown any of the following respiratory signs? (Please check as many as applicable)

- ☐ Increased respiratory noise (see Q5)
- ☐ Excessive panting
- ☐ Throat-clearing/hacking
- ☐ Coughing
- ☐ Nasal discharge
- ☐ Collapsing episodes/breathing crisis
- ☐ Difficulty sleeping
- ☐ Night-time wakefulness
- ☐ Licking lips
- ☐ Reverse-sneezing

5. What respiratory noise does your dog make? (eg, loud, raspy, gurgly) _____

_____

6. How would you rate the severity of the above signs as far as adversely affecting activity (1 – 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

7. How frequently do you see the respiratory signs?
☐ Rare: once a while ☐ Occasional: once a week ☐ Often: 2-3 times per week ☐ All the time: almost seen everyday

8. Can your dog breathe through its nose? ☐ Yes ☐ No ☐ Not sure

9. Are signs worse during
☐ Exercise ☐ Excitement or Stress ☐ Hot Weather ☐ Humid Weather ☐ Unchanged

10. Does your dog snore when asleep? Never ☐ Rare ☐ Sometimes ☐ Often ☐ All the time

11. Does your dog have an unusual bark? ☐ Yes ☐ No ☐ Unsure Duration: _____
a. If yes, describe: _____

12. Has your dog ever had any trauma or undergone any surgery to its upper airway or neck region? ☐ Yes ☐ No
If yes, describe: ☐ Nostrils ☐ Tonsils ☐ Saccules ☐ Soft palate ☐ Thyroid ☐ Trauma Please describe below:

_____

_____

13. Does your dog have trouble eating/chewing or take longer to eat? ☐ Yes ☐ No Duration _____

14. Does your dog regurgitate after eating or drinking? ☐ Never ☐ Rare ☐ Sometimes ☐ Often ☐ All the time

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

☐ Cleft palate	☐ Runny eyes	☐ Runny nose	☐ Known Allergies	☐ Tonsillitis
☐ Megaesophagus	☐ Seizures	☐ Something up nose	☐ Heart Disease	☐ Pneumonia
☐ Other lung issues	☐ Obesity	☐ Ear disease	Other:	

Current Medications / Supplements: _____

_____

_____

Owner _____ Date _____ Clinician _____ Date _____