



Animal Name: _____ Client Name : _____

Phone numbers we can reach you at today: 1(_____) 2) _____

If we are unable to reach you regarding our initial exam findings and recommendations, how would you like us to proceed? (Please choose one of the following options)

- Do whatever the Doctor recommends.
- Wait until we are able to contact you. This may result in a delay of initial care.
- Proceed with recommended care, but do not exceed a total cost of \$ _____.

Available pick up times: 10 am-----12 pm-----2 pm-----4 pm-----5 :30 pm
(Circle or indicate the general times you are available)

Is there a doctor who usually sees this pet or do you have a preference? YES NO If yes: Dr. _____

Approx. how old is your pet? _____ Has your pet been spayed or neutered? YES NO

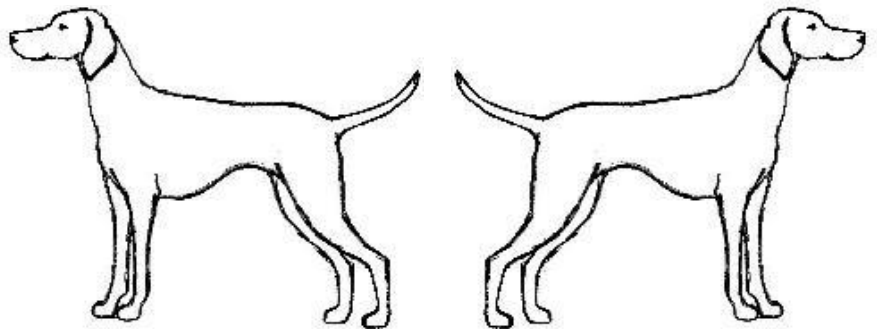
What are we seeing your pet for today?

Primary Complaints: (Please check all that apply)

- | | | | | |
|---|---|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Growth /Lump | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Eyes | <input type="checkbox"/> Ears | <input type="checkbox"/> Inappropriate Urination |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Painful | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lameness/Limping |
| <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Itching | <input type="checkbox"/> Lethargic | <input type="checkbox"/> Hair Loss | <input type="radio"/> Front/Hind <input type="radio"/> <input type="radio"/> Right/Left <input type="radio"/> |

How long has your pet been showing the above symptoms? _____

If your pet has any unusual lumps, bumps, wounds or skin irritation you would like the doctor to address today, please note on the diagram.



Other information you think may be pertinent including recent illness, surgery, and ANY medications you have given:

