

Is your pet exhibiting any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lethargy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Difficulty Bowel mvmt. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered yes to any of the above?

How often _____
When was the last time? _____

Does your pet have any drug allergies, recent surgeries, trauma or medical conditions?

Yes No

If Yes, please explain: _____

Has your pet ever had a vaccine reaction?

Yes No

If Yes, please explain: _____

Is your pet Pregnant/Breeding/Nursing

yes no

Is your pet on Ivermectin Yes No

Is your pet under 14weeks, under 5lbs?

Yes No

Has your pet ever tested positive for

Heartworms? Yes When _____ No

History of seizures Yes No

If yes How often _____

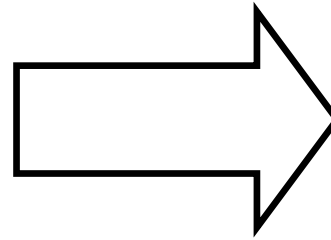
When was the last seizure? _____

Is your pet on medication? _____

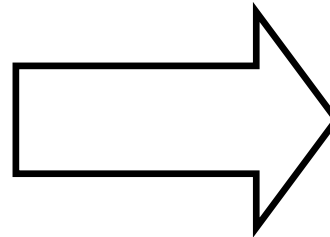
Is your pet currently on any medications, or supplements including heartworm prevention and flea control? Or received recent injections?

Yes No

If yes, what medication and why.



FOR
OFFICE
USE
ONLY



Patient Name: _____

Temp: _____ HR _____ RR _____

Last Clinical Exam _____

Reason Vitals not taken: Fractious Other

Prescription for:

- | | | |
|--------------------------------|---------------------------------|---------------------------|
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | Trifexis,/Interceptor |
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | Heartgard/Advantage Multi |
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | Comfortis,/Nexgard |
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | Bravecto/Credelio |
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | DeWorming |
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | All HW preventions |
| <input type="checkbox"/> aprvd | <input type="checkbox"/> denied | All Flea/Tick preventions |

(N-Normal, AB- Abnormal)

- | | | |
|----------------------------|-----------------------------|--|
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Temp |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Ears |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Eyes |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Nose |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Throat <input type="checkbox"/> Tarter |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Gum Color |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Murmur <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Lungs |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | PLN |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | Skin |
| <input type="checkbox"/> N | <input type="checkbox"/> AB | General Appearance/Condition |

Comments/Recommendations to client:

Recommend Full Service for any of the abnormalities indicated above and:

Diet Dental Alter

Senior/ 1st puppy or kitten exam

Check Following:

aprvd denied Vaccines

aprvd denied SX

aprvd denied RX

Veterinarian: _____