



Canine Examination Report

DATE: _____.

_____ is a _____ yr old _____ (breed/sex) presenting for _____.

Due for (circle): Rabies, Distemper/Parvo, Lepto, Bordetella, Fecal, HWT, Bloodwork.

Food Dental care Flea/Tick HWP Other meds/supplements: _____

Temp: _____ Pulse quality: _____ RR/Effort: _____ MM/hydration: _____ CRT: _____

1. Which best describes your dog's lifestyle? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Mostly indoor with daily walks | <input type="checkbox"/> Equal indoor/outdoor time | <input type="checkbox"/> Outdoor 100% |
| <input type="checkbox"/> Fenced yard-Supervised | <input type="checkbox"/> Fenced yard-Unsupervised | <input type="checkbox"/> Free roam on unfenced property |
| <input type="checkbox"/> Board | <input type="checkbox"/> Groom | <input type="checkbox"/> Obedience/Training classes |
| <input type="checkbox"/> Hike | <input type="checkbox"/> Access to lake/creek/river | <input type="checkbox"/> Contact with other dogs |
| <input type="checkbox"/> Travel: _____ | <input type="checkbox"/> Access to areas where ticks may be present | <input type="checkbox"/> Access to areas with wildlife |

2. Is your dog currently receiving Heartworm prevention? Brand: _____

How often? Summer Monthly year-round Inconsistent Last administered: _____

3. Is your dog currently receiving Flea/Tick prevention? Brand: _____

How often? Summer Monthly year-round Inconsistent Last administered: _____

4. List Current medications/supplements, dose, and frequency: _____

5. What is the name of your dog's food? _____ Amount/frequency: _____

Type/Frequency: Treats: _____ People food: _____

6. Do you provide dental care for your dog? Type/Frequency: _____

7. Other pets in household: None. Cats _____ Dogs _____ Birds _____ Reptiles _____ Other _____

Are they currently vaccinated and on flea/heartworm preventative? No Yes

8. Concerns/Abnormalities (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Change in appetite or drinking: _____ | <input type="checkbox"/> Coughing: _____ |
| <input type="checkbox"/> Change in defecation or urination: _____ | <input type="checkbox"/> Sneezing: _____ |
| <input type="checkbox"/> Vomiting: _____ | <input type="checkbox"/> Behavior: _____ |
| <input type="checkbox"/> Weight loss or gain: _____ | <input type="checkbox"/> Itchy/rash/lumps: _____ |
| <input type="checkbox"/> Other: _____ | |



Feline Examination Report

DATE: _____.

_____ is a _____ yr old _____ (breed/sex) presenting for _____.

Due for (circle): Rabies, FVRCP, Leukemia, Fecal, FIV/FelV Test, Bloodwork.

Food Dental care Flea/Tick HWP Other meds/supplements: _____

Temp: _____ Pulse quality: _____ RR/Effort: _____ MM/hydration: _____ CRT: _____

1. Which best describes your cat's lifestyle? (check all that apply)

- Indoor 100% Indoor/outdoor Outdoor 100%
- Screened porch/patio access Outdoor access-Supervised Outdoor access- Unsupervised
- Contact with other cats Board Groom Travel: _____
- Access areas where ticks may be present

2. Is your cat currently receiving Heartworm prevention? Brand: _____

How often? Summer Monthly year-round Inconsistent Last administered: _____

3. Is your cat currently receiving Flea/Tick prevention? Brand: _____

How often? Summer Monthly year-round Inconsistent Last administered: _____

4. List Current medications/supplements, dose, and frequency: _____

5. What is the name of your cat's food? _____ Frequency/Amt: _____

Type/Frequency: Treats: _____ People food: _____

6. Do you provide dental care for your cat? Type/Frequency: _____

7. Other pets in household: None. Cats ____ Dogs ____ Birds ____ Reptiles ____ Other ____

Are they currently vaccinated and on flea/heartworm preventative? No Yes

8. Type of litter: _____ Number of litter boxes: _____ Locations: _____

Cleaning schedule: Daily 3-4 times/week 1-2 times/week when it's full other: _____

9. Concerns/Abnormalities (check all that apply):

- Change in appetite or drinking: _____ Coughing: _____
- Change in defecation or urination: _____ Sneezing: _____
- Vomiting: _____ Behavior/grooming habits: _____
- Weight loss or gain: _____ Itchy/rash/lumps: _____
- Other: _____