

ANIMAL CLINIC EAST
1640 E Isaacs Avenue ♦ Walla Walla ♦ WA ♦ 99362

PREVENTIVE CARE EXAM

Appointment Date:

Client Name:

Client Address:

City, State, Zip Code:

Phone:

Email Address:

Email Reminders: / (circle one)

Patient Name:

Dog Cat Other

Breed Color

Spayed Neutered Intact

Age: Weight:

Microchip#:

Do you have any questions or special concerns at this time?

Annual fecal screening is recommended. Would you like to add a fecal screening today for an additional \$92? Yes / No (circle one)

If your pet is **not** microchipped, would you like us to implant one today for \$63? Yes / No (circle one)

Medication(s):

Known adverse reactions to any medications:

Lifestyle

- | | | |
|---|---|--|
| <input type="checkbox"/> Indoors only | <input type="checkbox"/> Visits Groomer | <input type="checkbox"/> Dog Park |
| <input type="checkbox"/> Boarding/Doggy Daycare | <input type="checkbox"/> Attends Dog Shows | <input type="checkbox"/> Hunting/Hiking (dogs) |
| <input type="checkbox"/> Hunter (cats) | <input type="checkbox"/> Flea/Tick Treatment: What Type? <input type="text"/> | <input type="checkbox"/> |
- Travel outside the Pacific Northwest? Where

Have you observed any of the following recently? Please check all that apply.

Diet/Oral Health

- | | | | |
|---|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Increased Appetite | <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Trouble Chewing Food | <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Bad Breath | |
- What food are you feeding? Is this a grain-free diet? (dogs only)

Behavior/ Neurologic

- | | | |
|--|--|---|
| <input type="checkbox"/> Change in behavior | <input type="checkbox"/> Tremors/shaking | <input type="checkbox"/> Vision/hearing changes |
| <input type="checkbox"/> Confusion or disorientation | <input type="checkbox"/> Excessive barking/meowing | <input type="checkbox"/> Change in sleeping pattern |

Body Functions

- | | | |
|--|--|---|
| <input type="checkbox"/> Loss of housetraining | <input type="checkbox"/> Increased Urination | <input type="checkbox"/> Scooting |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Repeated Vomiting | <input type="checkbox"/> Shaking head/scratching ears |
| <input type="checkbox"/> Changed Bowel Habits: Diarrhea / Constipation | | |

Heart / Lungs

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Excessive panting | <input type="checkbox"/> Tires easily/ short of breath |
|-----------------------------------|--|--|

Orthopedics

- | | |
|---|--|
| <input type="checkbox"/> Difficulty jumping up/ climbing stairs | <input type="checkbox"/> Showing signs of pain |
| <input type="checkbox"/> Increased stiffness or limping | <input type="checkbox"/> Not as active |

Skin and coat

- | | |
|--|---|
| <input type="checkbox"/> Scratching, licking, chewing | <input type="checkbox"/> Change in hair, coat, skin |
| <input type="checkbox"/> Unusual or new lumps or bumps | <input type="checkbox"/> Odor to skin |

Updated in DVMax (initials)