

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

**SENIOR PREVENTIVE CARE EXAM**

Appointment Date:

Client Name:   
Client Address:   
City, State, Zip Code:   
Phone:   
Email Address:   
Email Reminders: Y  / N

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

Current Medication(s):

Known adverse reactions to any medications:

**Lifestyle**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Indoors only (cats)      | <input type="checkbox"/> Groomer               | <input type="checkbox"/> Dog Park      |
| <input type="checkbox"/> Boarding or Dog Day Care | <input type="checkbox"/> Hunting/Hiking (dogs) | <input type="checkbox"/> Hunter?(cats) |

- Flea/Tick Treatment: What Type?
- 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 / How much 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)