Brea Veterinary Hospital

Owner: _____ Date: _____
Pet's Name: _____
Reason for Exam: _____ Duration of Problem_____
Please describe any changes: _____
_____
_____
_____

Please Check the Following:
Activity Level: Normal ____ Decreased _____ Increased _____
Appetite: Normal ____ Decreased _____ Increased _____
Water Intake: Normal ____ Decreased _____ Increased _____

Urination: Normal ____ Decreased _____ Increased _____
Any blood or straining during urination? _____
Any leakage detected? _____ Any Accidents?_____

Bowel Movement: Normal _____ Decreased _____ Increased _____
Diarrhea? _____ If Yes, any blood or mucus? _____
Worms Seen? _____ Describe _____

Coughing? No ____ Yes ____ How Long _____
Describe_____
Sneezing? No ____ Yes ____ How Long _____
Describe_____
Vomiting? No ____ Yes ____ How Long _____
Describe_____
Itching? No ____ Yes ____ If Yes, where?_____

Discharge Present? Eyes ____ Ears ____ Nose ____ Vagina ____ Penis _____
Describe Discharge _____

What do you feed your pet? _____

Current Medications, Supplements, Flea Control (Please indicate your pet's current dose): _____
_____

IF YOUR DOG IS NOT SPAYED, GIVE DATE OF LAST HEAT CYCLE _____
CATS: INDOOR ONLY _____ BOTH INDOOR AND OUT _____

Owner/Responsible Party _____

Please call me at (_____) _____ after examination with a treatment plan estimate.