



DROP OFF EXAM FORM:

Appetite normal? YES___ NO___ What diet? Any recent changes? _____

Water consumption normal? YES___ NO___ How long? _____

Weight loss/gain? YES___ NO___ Which and how long? _____

Diarrhea? YES___ NO___ How long? _____ Blood in stool? YES___ NO___

Urination normal? YES___ NO___ what changes/How long? _____

Vomiting? YES___ NO___ How long? _____

Lethargic? YES___ NO___ How long? _____

Coughing? YES___ NO___ How long? _____

Sneezing? YES___ NO___ How long? _____

Unusual discharge? YES___ NO___ Where & how long? _____

Lameness/limping? YES___ NO___ How long/which leg? _____

Stiffness? YES___ NO___ How long? _____

Difficulty rising? YES___ NO___ How long? _____

After sleeping? YES___ NO___ After exercise? YES___ NO___

Other notes that we should be aware of?

After examination by the Doctor, may we proceed with tests and/or treatment?

YES___ NO___ call first _____

Contact # _____