

----- **Animal Hospital**  
 Address  
 City State Zip

Veterinarian (555) 123-1234

Pet's Name _____	
Owner's Name _____	
Weight _____	Thin <input type="checkbox"/>
	Normal <input type="checkbox"/>
Temp _____	Overweight <input type="checkbox"/>

**EXAMINATION CHECKLIST**

**1. Coat & Skin**

- |  |                                   |                                      |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Appear Normal | <input type="checkbox"/> Oily     | <input type="checkbox"/> Itchy       |
| <input type="checkbox"/> Dull          | <input type="checkbox"/> Shedding | <input type="checkbox"/> Parasites   |
| <input type="checkbox"/> Scaly         | <input type="checkbox"/> Matted   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dry           | <input type="checkbox"/> Tumors   | _____                                |

**2. Eyes**

- |   |                                    |                 |
|---|------------------------------------|-----------------|
| <input type="checkbox"/> Appear Normal      | <input type="checkbox"/> Infection |                 |
| <input type="checkbox"/> Discharge          | <input type="checkbox"/> Cataract: | L _____ R _____ |
| <input type="checkbox"/> Inflamed           | <input type="checkbox"/> Other     | _____           |
| <input type="checkbox"/> Eyelid Deformities |                                    | _____           |

**3. Ears**

- |  |   |                 |
|--|---|-----------------|
| <input type="checkbox"/> Appear Normal | <input type="checkbox"/> Tumor:         | L _____ R _____ |
| <input type="checkbox"/> Inflamed      | <input type="checkbox"/> Excessive Hair |                 |
| <input type="checkbox"/> Itchy         | <input type="checkbox"/> Other          | _____           |
| <input type="checkbox"/> Mites         |   | _____           |

**4. Nose & Throat**

- |  |  |
|--|--|
| <input type="checkbox"/> Appear Normal   | <input type="checkbox"/> Inflamed Tonsils      |
| <input type="checkbox"/> Nasal Discharge | <input type="checkbox"/> Enlarged Lymph Glands |
| <input type="checkbox"/> Inflamed Throat | <input type="checkbox"/> Other _____           |

**5. Mouth, Teeth, Gums**

- |   |  |
|---|--|
| <input type="checkbox"/> Appear Normal  | <input type="checkbox"/> Inflamed Lips |
| <input type="checkbox"/> Broken Teeth   | <input type="checkbox"/> Loose Teeth   |
| <input type="checkbox"/> Tartar Buildup | <input type="checkbox"/> Gingivitis    |
| <input type="checkbox"/> Tumors         | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Ulcers         |  |

**6. Legs & Paws**

- |  |   |
|--|---|
| <input type="checkbox"/> Appear Normal     | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Lameness          | <input type="checkbox"/> Nail Problems  |
| <input type="checkbox"/> Damaged Ligaments | <input type="checkbox"/> Other _____    |

**7. Heart**

- |   |                               |                                      |
|---|-------------------------------|--------------------------------------|
| <input type="checkbox"/> Appears Normal | <input type="checkbox"/> Slow | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Murmur         | <input type="checkbox"/> Fast | _____                                |

**8. Abdomen**

- |  |  |
|--|--|
| <input type="checkbox"/> Appears Normal  | <input type="checkbox"/> Abnormal Mass |
| <input type="checkbox"/> Enlarged Organs | <input type="checkbox"/> Tense/Painful |
| <input type="checkbox"/> Fluid           | <input type="checkbox"/> Other _____   |

**9. Lungs**

- |   |   |
|---|---|
| <input type="checkbox"/> Appear Normal  | <input type="checkbox"/> Breathing Difficulty |
| <input type="checkbox"/> Abnormal Sound | <input type="checkbox"/> Rapid Respiration    |
| <input type="checkbox"/> Coughing       | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Congestion     |   |

**10. Gastrointestinal System**

- |   |   |
|---|---|
| <input type="checkbox"/> Appears Normal   | <input type="checkbox"/> Abnormal Feces |
| <input type="checkbox"/> Excessive Gas    | <input type="checkbox"/> Parasites      |
| <input type="checkbox"/> Vomiting Problem | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Anorexia         |   |

**11. Urogenital System**

- |   |  |
|---|--|
| <input type="checkbox"/> Appear Normal      | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Excessive Gas      | <input type="checkbox"/> Mammary Tumors    |
| <input type="checkbox"/> Genital Discharge  | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Abnormal Testicles |  |

**12. Anal Sacs**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Appear Normal    | <input type="checkbox"/> Abscessed   |
| <input type="checkbox"/> Excessively Full | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Infected         |                                      |

**13. Laboratory Tests**

- |   |                                   |   |
|---|-----------------------------------|---|
| <input type="checkbox"/> Heartworm Exam       | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive _____ |
| <input type="checkbox"/> Intestinal Parasites | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive _____ |

**VACCINATION PROGRAM**

- |                                      |                    |                 |              |              |              |              |           |
|--------------------------------------|--------------------|-----------------|--------------|--------------|--------------|--------------|-----------|
| <input type="checkbox"/> Up To Date  |                    |                 |              |              |              |              |           |
| <input type="checkbox"/> Vac. Due:   | Kennel Cough _____ | DA2LP/CPV _____ | Rabies _____ | FVRC-P _____ | Feleuk _____ | FIP _____    |           |
| <input type="checkbox"/> Vac. Given: | Kennel Cough _____ | DA2LP/CPV _____ | Lyme _____   | Rabies _____ | FVRC-P _____ | Feleuk _____ | FIP _____ |

**CURRENT CONDITION**

- |   |  |
|---|--|
| <input type="checkbox"/> Normal (Thank you for doing such a good job) | <input type="checkbox"/> Abnormal (But no action necessary at this time) |
| <input type="checkbox"/> Abnormal (Action is necessary now)           | <input type="checkbox"/> Abnormal ( <b>immediate action necessary</b> )  |

Recommendations:

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