

Animal Hospital
 Address _____
 City State Zip _____
 Veterinarian _____ (555) 123-1234

| | |
|--------------------|-------------------------------------|
| Pet's Name _____ | |
| Owner's Name _____ | |
| Weight _____ | Thin <input type="checkbox"/> |
| Temp _____ | Normal <input type="checkbox"/> |
| | 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 Prostrate |
| <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"/> Appears 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 (immediate action necessary) |

Recommendations:
