

Pet's Name: _____ Owner: _____ Date: _____

Current Symptoms

Check the box of any/all symptoms or problems that you have noticed about your pet recently:

		Doctor Notes
<p><u>General</u></p> <p><input type="checkbox"/> Increase in weight</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Lack of energy</p> <p><input type="checkbox"/> Increase in energy</p>	<p><input type="checkbox"/> Increase in appetite</p> <p><input type="checkbox"/> Decrease in appetite</p> <p><input type="checkbox"/> Increased drinking</p> <p><input type="checkbox"/> Decreased drinking</p>	
<p><u>Skin</u></p> <p><input type="checkbox"/> Scratching</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Skin / body odor</p>	<p><input type="checkbox"/> 'Scooting' rear end</p> <p><input type="checkbox"/> New lumps / bumps Where? _____</p>	
<p><u>Ears:</u></p> <p><input type="checkbox"/> Head shaking</p> <p><input type="checkbox"/> Ear discharge Left Right</p>	<p><u>Eyes:</u></p> <p><input type="checkbox"/> Vision problems</p> <p><input type="checkbox"/> Eye discharge Left Right</p>	
<p><u>Respiratory:</u></p> <p><input type="checkbox"/> Sneezing</p> <p><input type="checkbox"/> Gagging/drooling</p> <p><input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Excessive panting</p> <p><input type="checkbox"/> Labored breathing</p>	<p><u>Urinary:</u></p> <p><input type="checkbox"/> Excessive urination</p> <p><input type="checkbox"/> Straining to urinate</p> <p><input type="checkbox"/> Incontinence/dribbling</p> <p><input type="checkbox"/> Blood in urine</p>	
<p><u>Digestive</u></p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea / Loose stool</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Belching</p> <p><input type="checkbox"/> Excessive gas / flatulence</p>	<p><u>Teeth/Oral Cavity:</u></p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Tooth loss</p> <p><input type="checkbox"/> Difficulty eating / drinking</p> <p><input type="checkbox"/> Lack of appetite</p> <p><input type="checkbox"/> Gums bleeding / red</p>	
<p><u>Orthopedic:</u></p> <p><input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> Swellings</p> <p><input type="checkbox"/> Toenail problems</p> <p><input type="checkbox"/> Limping - which leg? _____</p>	<p><u>Neurologic:</u></p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Loss of balance/dizzy</p> <p><input type="checkbox"/> Shaking</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Head tilt</p>	
<p><u>Behavior:</u></p> <p><input type="checkbox"/> Fears / Anxiety</p> <p><input type="checkbox"/> Aggression</p> <p><input type="checkbox"/> Inappropriate urine/stool</p> <p><input type="checkbox"/> Other: _____ _____</p>	<p><u>Any other concerns?</u></p> <p>_____</p> <p>_____</p> <p>_____</p>	