

Vaccination History (Date and type of vaccinations) \_\_\_\_\_

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Please check any symptoms or problems that you have noticed about your pet:

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|---|---|--|
| <input type="checkbox"/> Behavior Problems        | <input type="checkbox"/> Lack of Appetite | <input type="checkbox"/> Sneezing                          |
| <input type="checkbox"/> Bleeding Gums            | <input type="checkbox"/> Limping          | <input type="checkbox"/> Thirst and/or Urination Increased |
| <input type="checkbox"/> Breathing Problems       | <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Vomiting                          |
| <input type="checkbox"/> Coughing                 | <input type="checkbox"/> Scooting         | <input type="checkbox"/> Weakness                          |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Scratching       | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Eye Bulging or Bloodshot | <input type="checkbox"/> Seems Depressed  |  |
| <input type="checkbox"/> Gagging                  | <input type="checkbox"/> Shaking Head     |  |

Pets Current Medications \_\_\_\_\_

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Describe your pet's diet \_\_\_\_\_

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### AUTHORIZATION

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and a deposit may be required for surgical treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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