

DATE / /	CLIENT																		
	PET NAME																		
CLASS	<input type="checkbox"/> CANINE	<input type="checkbox"/> EQUINE	SEX		AGE		BREED												
	<input type="checkbox"/> FELINE	<input type="checkbox"/> OTHER	<input type="checkbox"/> M	<input type="checkbox"/> CM															
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> F	<input type="checkbox"/> SF															

NOTE: PLEASE FILL IN ALL APPROPRIATE BOXES COMPLETELY.

TYPE OF EXAM

NUMBER OF FILMS:

<input type="checkbox"/> 8070 1-5 Films	<input type="checkbox"/> 8071 6-10 Films	Abdomen <input type="checkbox"/>	Spine <input type="checkbox"/>	Nasosinus <input type="checkbox"/>	Esophagram <input type="checkbox"/>	Barium Enema <input type="checkbox"/>	Cystogram <input type="checkbox"/>
<input type="checkbox"/> 8072 11-15 Films	<input type="checkbox"/> 8073 15+ Films	Pelvis <input type="checkbox"/>	Skull <input type="checkbox"/>	Extremity <input type="checkbox"/>	UGI Contrast <input type="checkbox"/>	IVP <input type="checkbox"/>	Myelogram <input type="checkbox"/>
		Thorax <input type="checkbox"/>					

CLINICAL COMPLAINT

Anorexia <input type="checkbox"/>	Coughing <input type="checkbox"/>	Seizures <input type="checkbox"/>	Hematuria <input type="checkbox"/>	Lameness <input type="checkbox"/>
Vomiting <input type="checkbox"/>	Panting <input type="checkbox"/>	Syncope <input type="checkbox"/>	Stranguria <input type="checkbox"/>	Right Front <input type="checkbox"/>
Constipation <input type="checkbox"/>	Polyuria <input type="checkbox"/>	Ataxia <input type="checkbox"/>	Urinary Obst. <input type="checkbox"/>	Left Front <input type="checkbox"/>
Diarrhea <input type="checkbox"/>	Polydipsia <input type="checkbox"/>	Paralysis <input type="checkbox"/>	Pollakiuria <input type="checkbox"/>	Right Rear <input type="checkbox"/>
Regurgitation <input type="checkbox"/>	Weakness <input type="checkbox"/>	Blindness <input type="checkbox"/>		Left Rear <input type="checkbox"/>
Dysphagia <input type="checkbox"/>	Lethargy <input type="checkbox"/>	Hair Loss <input type="checkbox"/>		

PHYSICAL EXAM

SUBJECTIVE

BARH Depressed Weak Obese Thin Dehydrated Icteric Anemic Dental Disease Sceral Injection

Cardiovascular

Heart rate: Normal Rapid Slow Gallop Rhythm Arrhythmia

Murmur: Left Base Left Apical Systolic Diastolic 2/6 4/6
 Right Side None Continuous 1/6 3/6 5/6

Femoral Pulses: Good Fair Poor Jugular Pulses:

Mucuous Membranes: Normal Cyanotic Pale Slow CRT

Respiratory

Tachypnea Dyspnea Crackles Wheezes Stridor

Cough: Dry Honking Harsh Moist Mild

Occurs with: Excitement Nocturnal Occasional Tracheal Palpation

Abdomen

Painful

Palpable Mass

Ascites

Distended

Hepatomegaly

Splenomegaly

Orthopedic

Normal

Swelling

Muscle Wasting

Anterior Drawer Motion

Pain On: Flexion

or Extension

LAB WORK ABNORMALITIES

Anemic <input type="checkbox"/>	Hypercalcemia (Ca) <input type="checkbox"/>	Elevated Liver Enzymes <input type="checkbox"/>	FeLV (+) <input type="checkbox"/>	Pyouria <input type="checkbox"/>
Lymphocytosis <input type="checkbox"/>	Hyperkalemia (K) <input type="checkbox"/>	Bilirubinemia <input type="checkbox"/>	Heartworm (+) <input type="checkbox"/>	Proteinuria <input type="checkbox"/>
Neutrophilia <input type="checkbox"/>	Hypokalemia (K) <input type="checkbox"/>	FIP (+) <input type="checkbox"/>	Hyperthyroidism <input type="checkbox"/>	Hematuria <input type="checkbox"/>
Hypoalbuminemia <input type="checkbox"/>	Azotemia <input type="checkbox"/>	FIV (+) <input type="checkbox"/>	Hypothyroidism <input type="checkbox"/>	Crystaluria <input type="checkbox"/>

ADDITIONAL HISTORY ON REVERSE SIDE OF FORM.

ADDITIONAL HISTORY INFORMATION:

Lined area for entering additional history information.

OTHER PERTINENT INFORMATION:

Lined area for entering other pertinent information.