LAKE ANNA VETERINARY HOSPITAL
11012 Kentucky Springs Road
Mineral, VA 23117
Tel: 540-894-4572

Date: __/__/__

Patient Assessment

Owner Name:_____ Name of Patient:_____
2nd Owner if any: _____ Sex:_____Spayed/Neutered?_____
Address:_____ Species: _____ Breed:_____
Phone:_____ Color: _____
Email Address: _____ Age: _____
Approx Weight: _____

Last Done	Due Date	Last Done	Due Date

Please circle answers that apply to your pet.

1. How much time does your pet spend outside each day? (Circle one)

Completely outdoors **Indoor/outdoor 50/50** **Mostly Indoors** **Strictly Indoors**

2. Does your pet participate in any of the following activities? (circle all that apply)

Dog Parks **Dog Daycare** **Boarding Facility** **Grooming Salon**

Training Classes **Competition Events** (conformation, agility, obedience, etc.)

3. Do you travel with your pet? **Yes** **No**

4. Do you take your pet hiking, hunting, camping or fishing? **Yes** **No**

5. Do you observe wildlife or non-domesticated animals in your neighborhood? **Yes** **No**

6. Do you or your pet visit homes where there are pets? **Yes** **No**

7. Do other pets come to visit at your house? **Yes** **No**

8. Does your pet live with anyone with immune system issues/undergoing chemo? **Yes** **No**

9. Do young children have contact with your pet? **Yes** **No**

10. Have you seen evidence of fleas, ticks, worms on the pet we are seeing today or on any pets in your home? **Yes** **No**
Do you use a flea and tick preventative? If so, what brand? _____

11. If your pet is a cat, does he/she use a litter box, go outside or both? **litter box** **outdoors** **both**

12. Do you give your pet medication for pain? **Yes** **No**

13. Do you give your pet any over the counter/Supplements OR prescription medications? **Yes** **No**

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May 3, 2016
Account # 33729

Current Medications/Supplements: _____ _____ _____

14. What dental care products do you use: circle all that apply:

Rinses / Sprays **Toothpaste/brush** **Rawhide chews** **Other** _____

15. Is your pet currently on **Heartworm Preventative**? **Yes** **No**
If so, what product do you use?

Sentinel **Interceptor** **Heartgard** **Trifexis**

Revolution **Pro-Heart Injectable** **Other:**_____

16. What kind of diet do your feed your dog/cat? (ex: wet, moist, dry, brand name, grain-free, etc.)

_____

17. Do you give treats to your dog/cat? **Yes** **No**

If Yes, **What type**? _____ **How often** do you give treats? _____

18. What kind of exercise does your pet get? _____

19. Does your pet scratch, bite at its skin or seem "itchy"? **Yes** **No**

20. Have you observed weight loss / weight gain in your dog/cat? **Weight Gain** **Weight Loss** **Neither**

21. Have you noticed a change in water consumption or urination amount? **Yes** **No**

22. Have you noticed any recent change in your pet's activity level or behavior? **Yes** **No**

If yes: **Details:**_____

23. Have you observed any signs of pain: (circle all that apply)

slow to get up/down **tremors** **excessive panting** **rear leg weakness** **guarding areas of body**

24. Have you observed any recent changes in your pet's behavior when urinating or defecating?

Please describe changes: _____

25. How many household pets? Please indicate number of each. **Dogs** ____ **Cats**____ **Other** ____

26. Is there anything else you would like us to know about your pet's medical history or personality?

_____

Signature: _____ Date: _____

Print Name _____