# Exam History Form

Old Mill Veterinary Hospital

Name:_____

Pet's Name: _____

Cell phone: _____

Date: _____

Please have this form **completed** before coming to the hospital. You can email it back before your appointment or bring it with you. Your pet will be brought into the hospital by a team member, the doctor will do an exam and any questions/conversations will be by phone. Please have a cell phone ready and the number of that phone on this form. Payment of services will be curbside as well, and expected after the visit is complete.

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| **Curbside appointment** | Please arrive 10mins before your appointment time | **Email: omvhrecords@gmail.com**<br>**FAX: 703-779-7440**<br>**Questions? Call: 703-779-2903** |
| **Park** | Please let us know where you have parked, the make, color and model of your car. | |
| **Notifying us of your arrival** | Please call our office once you have arrived | ☐ Check here if you require a printed treatment plan with cost estimate. |
| **Pet prepared** | Please have your pet on a leash or in a carrier before we come to the car | If requested, please have a fecal and/or urine sample available |

| Question | Circle yes or no | Comments |
|---|---|---|
| **Briefly describe the reason your pet is here for an exam, such as ear infection, sick or limping. Please answer all questions below regardless of why your pet is here.** | | |
| **Has your pet had any coughing ?** | Yes No | |
| **Has your pet had any sneezing ?** | Yes No | |
| **Does your pet have any nasal discharge? If yes what color and which nostril(s)?** | Yes No | |
| **Has your pet been vomiting?** | Yes No | |
| **If your pet has been vomiting when was the last time and describe the vomit.** | | |
| **Has your pet had diarrhea?** | Yes No | |
| **Does your pet's stool look normal in color? If no, is it black or bloody?** | Yes No | |
| **Has your pet been drinking more?** | Yes No | |
| **Has your pet been urinating more?** | Yes No | |
| **Have you seen your pet's urine? If so what was the color and amount?** | Yes No | |
| **Has your pet's appetite changed and if so describe how?** | Yes No | |
| **When was the last time you saw a bowel movement and what did it look like?** | | |
| **Any change in diet? If yes, when and what did you change?** | Yes No | |
| **Is your pet lethargic (not active)? If yes, how long?** | Yes No | |
| **Is your pet here because it is limping? If so which leg and how long?** | Yes No | |
| **Please list all medications your pet is on and when they were last given:** | | |
| **Has your pet cried out? If so what was your pet doing when this occurred?** | Yes No | |

| Question | Circle yes or no | |
|---|---|---|
| **Does your pet have a problem with one or both of its eyes? Which eye, describe any drainage or symptoms.** | Yes No | |
| **Does your pet have a problem with one or both of its ears? Which ear, describe any discharge or symptoms.** | Yes No | |
| **Do you have a concern with your pet's teeth? If yes, describe.** | Yes No | |
| **Would you like your pet's nails trimmed while here? Comment if any concerns with the nails.** | Yes No | |
| **Would you like your pet's anal glands emptied? Comment if any concerns with them, any scooting or licking?** | | |
| **Are there any new lumps or bumps you have found? If so, where are they and how long have they been present?** | Yes No | |
| **Please use the rest of the sheet to write any information that you feel would be helpful in treating your pet today. We will do our best to have your pet seen and communicate a plan as quickly as possible.** | | |
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