



## Veterinary Exam Form

This form must be completed and signed by a licensed veterinarian and returned with your enrollment application by mail, fax or in person. For our new guests a veterinary exam must be completed **within 2 weeks prior to their first visit**. For the protection of all of our guests, failure to supply this information will be cause for cancellation of your dog's visit. **Note: You will need to bring along a fresh stool sample to your veterinarian for the fecal exam.**

Owner's Name(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Dog's Name \_\_\_\_\_ Breed \_\_\_\_\_ Age \_\_\_\_\_

Male  Female Spayed/Neutered?  Y  N Color \_\_\_\_\_ Weight \_\_\_\_\_

**Required Immunizations:** Please enter the date that the below listed vaccinations were last given

DHLPP \_\_\_\_\_ Rabies \_\_\_\_\_ Bordetella \_\_\_\_\_

1 year  3 Year  1 Year  3 Year

Required Annually

**Examination Information:** Please check all boxes that apply.

Date of last physical exam: \_\_\_\_\_ Dog's health is:  Poor  Fair  Good  Excellent

**Fecal** (req'd every 6 months)  Neg  POS (describe below)

Date of most recent test: \_\_\_\_\_

Diarrhea  Coccidian  
 Blood  Whipworm  
 Roundworm  Tapeworm

**Eyes**  Normal  Abnormal (describe below)

Conjunctivitis  Glaucoma  
 Ulcerated/Injured  
 Other \_\_\_\_\_

**Ears**  Normal  Abnormal (describe below)

Mites  Infection  
 Other \_\_\_\_\_

**Skin**  Normal  Abnormal (describe below)

Hot Spots  Fleas/Mites  
 Ringworm  Cysts  
 Tumors  Mange  
 Other \_\_\_\_\_

Is dog on monthly flea treatment?  Y  N

**Oral**  Normal  Abnormal (describe below)

Papillomas  Dental Problems  
 Sores  Other \_\_\_\_\_

**Skeletal**  Normal  Abnormal (describe below)

Hip Dysplasia  Broken Bone  
 Bone Abnormality  Arthritis

### **Kennel Cough**

Any kennel cough symptoms in the past 2 month? (coughing, sneezing, nasal discharge, etc)  Yes  No

### **Other Health Concerns**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **VETERINARIAN INFORMATION:**

Print Veterinarian's Name: \_\_\_\_\_ Clinic Name \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

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