

PATIENT NAME/OWNER LAST NAME _____

Date _____

Is your pet current on vaccines? (circle one): Yes No

Describe temperament: (i.e., high-energy, sometimes bites, etc.) _____

Please check off any present symptoms/conditions and when you first noticed the condition(s):

	Patient's <i>RIGHT</i> eye	Patient's <i>LEFT</i> eye	When did you first notice symptom(s)?
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what color?
Squinting	<input type="checkbox"/>	<input type="checkbox"/>	
Color change	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what color?
Redness	<input type="checkbox"/>	<input type="checkbox"/>	
Cloudiness	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged eye	<input type="checkbox"/>	<input type="checkbox"/>	
Rubbing at eye	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	Please describe:

	YES	NO	If yes, when did you first notice?
Changes in eating	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in water intake	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in energy level	<input type="checkbox"/>	<input type="checkbox"/>	
Changes in behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	To what?
History of seizures	<input type="checkbox"/>	<input type="checkbox"/>	

List any history of out-of-state travels/residence and for how long:

Please list any current or previous illnesses, injuries or surgeries.
If possible, please list the dates and diagnosis: (i.e., ACL surgery, left
knee, October 2004)

Please list all medications (mg per treatment
if you can) your pet is on for ANY illnesses or
prevention and the frequency you give them:
(i.e., Gentocin 1 drop in right eye twice daily)

- 1) _____
- 2) _____
- 3) _____
- 4) _____

PAYMENT

Charges for professional fees and dispensed medications are due at the time services/medications are rendered.
Please indicate which method of payment you anticipate using. (circle one): **Visa Mastercard Cash Check**

Driver's License # (only required if you are writing a check) _____

AUTHORIZATION

I hereby authorize Dr. Todd Hammond / Dr. Bradley Graham to examine, prescribe for, and/or treat my pet/patient. 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 professional services are rendered and that a deposit may be required for any procedures and/or surgeries
performed.

Signature of Owner/Agent/Guardian _____