VIRGINIA VETERINARY SURGICAL ASSOCIATES, P.C.

Welcome to Virginia Veterinary Surgical Associates

CLIENT INFORMATION

OWNER:

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____Mobile: (_____)_____Work: (_____)_____

Occupation: _____Email: _____

CO-OWNER/SPOUSE:

First Name: _____ Last Name: _____

Home Phone: (_____)_____Mobile: (_____)_____Work: (_____)_____

Occupation:_____

PET INFORMATION

Name: _____ ☐Canine ☐Feline Breed: _____

☐Male ☐Female ☐Neutered ☐Spayed Date of birth: _____/_____/_____ Color: _____

Does anyone else have permission to make decisions on behalf of your pet? Please list name and contact information.

_____

May we use information pertaining to your pet and your pet's case including a photo of your pet in our marketing efforts; including but not limited to our website, continuing education, charitable events, etc.? ☐ Yes ☐ No

PRIMARY CARE VETERINARIAN

Referring Veterinarian: _____ Name of Hospital: _____

Other Veterinarian: _____

I understand that payment in full is due at the time of service. I agree to assume financial responsibility for all professional fees, and agree to pay VVSA when services are rendered. I understand that a fee of $50.00 will be incurred for all returned checks and a finance charge of 1.5% per month will be applied to any unpaid balance. VVSA may also recover reasonable attorney's fees and court costs incurred as a result of my failure to pay in accordance with this authorization.

_____ _____

Owner signature date

_____ _____

Co-owner/spouse signature date

YOUR PET'S MEDICAL HISTORY

VIRGINIA VETERINARY SURGICAL ASSOCIATES, P.C.

An accurate and current medical history is one of the most important parts of our medical evaluation. Taking a few moments to fill out this questionnaire will provide our surgeons with insight to your animals' health and could offer assistance to them during the comprehensive physical examination.

What is the primary reason you are seeing a veterinary surgeon? ( ) Orthopedic ( ) Soft Tissue ( ) Neurologic

describe?_____

_____

When did you notice the condition? _____

Has your pet's general activity level: ( ) increased ( ) decreased ( ) remained normal

If increased or decreased, how long? _____

When your pet is outside, is she/he confined to a fenced yard or leashed? ( ) Yes ( ) No

Has your pet's water intake been: ( ) absent ( ) decreased ( ) increased ( ) normal

If abnormal, duration? _____

Has your pet's appetite been: ( ) absent ( ) decreased ( ) increased ( ) normal

If abnormal, duration? _____

What does your pet's diet consist of: ( ) Commercial Food ( ) Prescription Diet ( ) Table Scraps ( ) Other

Please list food(s) _____

When did your pet last eat? Date, time, and what? _____

Have you observed any lameness, limping, or difficulty walking? ( )Yes ( )No

Which limb(s) are affected? ( ) Right fore ( ) Left fore ( ) Right rear ( ) Left rear

Please describe other activities causing your pet difficulty? _____

_____

Have you noticed any unusual coughing? ( ) Yes ( ) No duration? _____

Have you noticed any unusual sneezing? ( ) Yes ( ) No duration?_____

Have you noticed any discharge from the ears, eyes, nose, mouth, rectum, or genitals? ( ) Yes ( ) No

Describe location, discharge characteristics and duration: _____

_____

Has there been any consistent vomiting? ( ) Yes ( ) No duration? _____

Has there been any consistent diarrhea? ( ) Yes ( ) No duration? _____

Has there been a consistent change in your pet's bowel movement frequency or stool consistency? ( ) Yes ( ) No

If yes, please describe changes and duration of changes: _____

_____

YOUR PET'S MEDICAL HISTORY CONTINUED

Have you observed any changes in your pet's urination behavior or frequency? ( ) Yes ( ) No

Please describe the changes and duration:

_____

Has your pet ever had a seizure? ( ) Yes ( ) No date of last seizure? _____ _____

Does your pet take any medication(s) to prevent seizures? ( ) Yes ( ) No

What medication(s), dose, and frequency? _____

_____

Has your pet traveled out of the Mid-Atlantic States? ( ) Yes ( ) No If yes, when and where? _____

_____

Are your pet's vaccinations current within the last 12 months? ( ) Yes ( ) No Year of last rabies vaccine? _____

Please describe all medication (including heartworm prevention and flea control) your pet is currently taking.

Please list name, strength, and times per day:_____

_____

_____

_____

_____

Has your pet ever experienced an adverse or allergic reaction to any medication? ( ) Yes ( ) No If yes, please describe? _____

_____

Has your pet had any significant injuries, illness, surgery, or medical problems in the past that are not covered in the previous questions? _____

_____

_____

_____

_____

Number of other pets that share the household: ( ) None Dog(s) _____ Cat(s) _____ Other _____

Please describe other? _____

Are any of these pets current or past patients of Virginia Veterinary Surgical Associates? ( ) Yes ( ) No

If yes, name of pet(s) _____