



Client-Patient Information

12021 Ironbridge Road | Chester, VA 23831
 (804) 748-2244 | fax: (804) 748-7260
 cac@lyneanimalhospitals.com

To ensure we have the most accurate, up-to-date information for you and your pet we ask that you complete this form **PRIOR** to your appointment. By filling this out ahead of time we will be able to update your records, allowing us to stream-line the check-in process as well as your appointment time. Please complete the form in its entirety.

Client's Full Name:

Last Name:

First/Middle Name:

Home Address:

Street (include Apt #, if applicable)

City, State , Zip Code

****Email Address:**

**Your email address is strictly used for internal purposes and for communication directly with you. We send out revised policies, inclement weather updates, estimates for boarding/medical services as well as surveys on how to improve our services.

Best Phone #'s to contact you:

Cell #:

Emergency/Alternate #:

We ask that your primary phone # be a cell phone number as we will text reservation confirmations, policies, reminders, etc via text.

Additional Owners to be included on your account:

Please list any one who will be financially and medically responsible for your pet(s) in case of emergency.

Spouse/Partner:

Spouse's/Partner's Cell#:

Please list all pets that should be active on your account. Only list pets that currently live in your household.

<u>Pet's Name</u>	<u>Species</u> K9/Fel/Other	<u>Breed</u>	<u>Sex</u>	<u>Color</u>	<u>Age</u>
1.					
2.					
3.					
4.					
5.					

M - Male F - Female N - Neutered SP - Spayed

What services will we be performing for your pet(s) during their appointment? *(please select all that apply)*

Canine Vaccines: Rabies Distemper/Parvo Infectious Tracheobronchitis Canine Influenza Lyme

Leptospirosis **Feline Vaccines:** Rabies FVRCP-C Feline Leukemia

Diagnostics: Heartworm Test Annual Bloodwork Bloodwork to refill Prescription Fecal Urinalysis

Nail Trim Anal Gland Expression

Other:



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Please indicate any medical concerns or changes in behaviors you've noticed since their last exam.

Arthritis	Cloudy Discharge from Eyes	Increase/Decrease in Appetite
Blindness	Gagging	New Lumps/Bumps/Masses
Deaf	Not Urinating	Thunderstorm Anxiety
Chewing/Licking at feet	Head Tilt	Incontinence
Walks in Circles	Lethargic	Limping
Constipation	Licking/Chewing at Skin	Weight Gain/Loss
Coughing	Nasal Discharge	Increased water intake
Sneezing	Seizures	Vomiting
Hacking	Frequent Urination	Fearful
Diarrhea	Wounds	Increase in size of Lumps/Bumps/Masses

What other concerns or issues do you want to make sure the Doctor addresses, examines or discusses with you during the exam?

Please indicate below all medications your pet is currently taking, **this includes prescribed medications, supplements, preventatives as well as over the counter products.**

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Last Dose Given</u>	<u>Purpose of Medication</u>
Example: Rimadyl	25mg tab	2 times/day	6PM-1/30	Arthritis
Example: Flex Chews	1 chew	1 time/day	10AM-1/30	Joint Supplement
Example: Interceptor Plus	1 chew	1 / month	1/1/20	Heartworm Preventative

What prescription refills will your pet need during their visit?

Heartworm Flea & Tick Insulin Thyroxine Flex Chews Rimadyl Anxiety Medication

Other:

Prescription Diet Food

Must be ordered by NOON on Monday to be delivered by Friday



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- **Is this a new pet for your family? If so, please indicate how long you've had them.**
And, where did you get them? Rescue Shelter Stray Breeder Other:
- **What food do you feed your pet?**
- **How many times per day are they fed? One Two Three Four**
And, how much are they fed AT EACH feeding?
1/2 cup 3/4 cup 1 cup 2 cups Other:
- **What kind of treats, snacks, table scraps and/or chews do you give your pet?**
- **Does your pet have any sensitivities (activities, situations, or areas on the body)? Yes No**
If so, please indicate what they are or what the triggers are:
- **Has your pet ever bitten anyone or other dogs? Yes No**
- **Has your pet ever shown anxieties when visiting the Veterinarian? Yes No**
- **Would you be interested in your pet receiving obedience training services? Yes No**
- **Please indicate if your pet will be exposed to any of the following:**
Doggie Daycare Boarding Grooming Training Local Dog Park Walks around Neighborhood
Pet-Friendly Stores/Malls Walks in the Woods/Trails Swimming in Neighborhood Lake/Creek/Pool
Wooded Backyard Other:
- **Will your pet primarily be inside or outside? Inside Outside**
 - **How much of their time will be spent outdoors?**
(Please indicate time spent outside, i.e. two hours, most of the day, just for potty breaks)
- **Indicate the activity level that best suits your pet: Very relaxed Moderate High Energy**
- **What dental care do you provide your pet at home:**
Brush teeth Oral rinse/gel Dental Diet CET Hextra Chews Greenies Purina Dental Chews
Drinking water additive None Other:
- **Has your pet been seen by another Veterinarian or been to the Emergency Hospital since your last visit?**
If so, who examined your pet, when was the visit and what were they seen for?
- **Are you receiving regular service reminders for your pet's medical services?**
- **We are now offering Wellness Plans, are you interested in learning more about our Wellness Plans?**
- **For some of our Medical Progress Exams we offer Telemedicine visits with the Veterinarian. This service offers "FaceTime" or video chat with the Veterinarian, would you be interested in learning about that service?**