DeSoto Animal Clinic
Veterinary Medicine
& Surgery

FELINE ANNUAL VISIT ADMISSION FORM

Date: _____

Owner's Name: _____ **Pet's Name:** _____

The primary purpose of an annual examination is to prevent disease or, at least, to discover abnormalities while they are still treatable. It is also the time to review previous health problems, monitor current medications and update immunizations.

Vaccination protocols have changed, and we no longer recommend every vaccine every year. The vaccination schedule is modified for each individual patient. Manatee County recognizes the 3-year Rabies vaccine and we suggest "distemper boosters" be extended to every three years as well. Other vaccines depend upon the exposure risk for your pet.

☐ **Vaccinate my pet per doctors' recommendations.**

☐ 1-year Rabies ☐ 3-year Rabies ☐ FVRC ☐ Panleukopenia ☐ Feline Leukemia

☐ 1-year County License Certificate*

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*To refuse the Manatee County License, please sign below. *(Note: a substantial fee may be imposed by Manatee County.)*

I refuse the Manatee County License. Signature _____ Date _____

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Additional Requests:

☐ Draw Blood for Laboratory Work-up ☐ Intestinal Parasite Screen *(recommended annually)*

☐ FeLV/FIV/HW combination test ☐ Nail Trim

Please list any specific concerns or problems with your pet: _____

_____

_____

What do you feed your pet? _____

When did your pet last eat? _____

When did your pet last drink? _____

Does your pet go outside? ☐ No ☐ Yes **If yes, how often and for how long?** _____

Is your pet on heartworm preventative? ☐ No ☐ Yes - Brand: _____

Is your pet on flea/tick medication? ☐ No ☐ Yes - Brand: _____

Is your pet on any other medications? ☐ No ☐ Yes - What? _____

Appetite:	☐ Normal	☐ Poor	☐ Anorexia	☐ Excessive		
Thirst:	☐ Normal	☐ Increased	☐ Decreased	☐ None		
Urination:	☐ Normal	☐ Increased	☐ Decreased	☐ Straining	☐ Bloody	
Stools:	☐ Normal	☐ Hard	☐ Soft	☐ Diarrhea	☐ Straining	☐ Bloody
Respiration:	☐ Normal	☐ Increased	☐ Coughing	☐ Sneezing		
Vomiting:	☐ Normal	☐ Food	☐ Mucus	☐ Bile	☐ Blood	

Other: _____

Permission for Diagnostics and Treatment. Please read before signing.

If we find the need for sedation or diagnostic labwork, would you like us to:

☐ Perform the procedures ☐ Contact you with an estimate (Phone #: _____)

Signature: _____ Date: _____

Home #: _____ Cell #: _____ Work #: _____

Please indicate your preferred contact number: _____

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