DeSoto Animal Clinic
Veterinary Medicine
& Surgery

CANINE 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 ☐ DA2PP ☐ Leptospirosis ☐ Bordetella
☐ 1-year County License Certificate* ☐ Borrelia (Lyme) ☐ Canine Influenza

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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:
☐ Nail Trim ☐ Express Anal Sacs ☐ Draw Blood for Laboratory Work-up ☐ Clean Ears
☐ Heartworm Test *(recommended annually)* ☐ Intestinal Parasite Screen *(recommended annually)*

Please list any specific concerns or problems with your pet: ____
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What do you feed your pet? ____
When did your pet last eat? ____
When did your pet last drink? ____
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 #: ______________________)

I permit DeSoto Animal Clinic to treat my pet within the above guidelines.

Signature: ____ Date: _________________________

Home #: ________________________ Cell #: ________________________ Work #: _______________________

Please indicate your preferred contact number: ____________

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