Drop-Off: WELLNESS

1434 W. Alabama St.
Houston, TX 77006

Phone: 713-528-4900
Fax: 888-504-9006
www.MidtownVetHospital.com

Today's Date: ____________

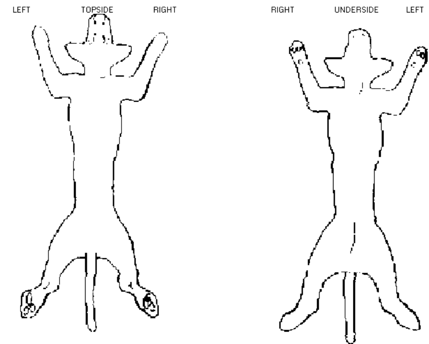
Contact Information

Owner's Name: ____________

Phone Number to Reach You *Today*: ____________

Additional Contact Information: ____________

Pet Information



Pet's Name: ____________

Has this pet visited our office before? ☐ Yes ☐ No

Reason For Today's Visit: WELLNESS EXAM

Examination: _____ Fecal: ___ Heartworm Test: ___

Vaccines: ____ DHP _____ Rabies ____Bordetella ______ Canine Influenza H3N8______ Leptospirosis ____ Rattlesnake __ Canine Influenza H3N2 ____ FVRCP _____ FeLV

Please note any concerns you have with your pet:

Change in Appetite: ☐ Increased ☐ Decreased

Change in Urination: ☐ Increased ☐ Decreased ☐ Discoloration ☐ Straining ☐ Accidents in house

Change in Water Consumption: ☐ Increased ☐ Decreased

Change in Weight: ☐ Increased ☐ Decreased

Change in Attitude, please describe: ____________

Excessive Scratching or Hair Loss, describe and indicate on diagram above: ____________

Limping, which leg: ____________

Lumps and Bumps, describe and mark on diagram below: ____________

Poison Ingestion, type and time when ingestion occurred: ____________

Seizure, frequency and severity: ____________

Other: ____________

Vomiting:: first time:__________ last time:_________consistency: __________

Diarrhea: first time:___________ last time_________ consistency:___________

ADDITIONAL SERVICES

Yes	No	
☐	☐	NAIL TRIM
☐	☐	MICROCHIP IMPLANT
☐	☐	CLEAN EARS

Yes	No	
☐	☐	EXPRESS ANAL GLANDS
☐	☐	SANITARY CLIP
☐	☐	OTHER:

Authorization

After we examine your pet, how would you like us to proceed with treatment?

☐ Proceed immediately with treatment at Veterinarian's discretion

☐ Proceed with treatment if the estimated cost is less than $ ________

☐ Call you with the findings of the examination and a cost estimate prior to initiating treatment

Deposits are required for all new accounts and for complicated procedures.
PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE PERFORMED.
In admitting my pet for diagnostics, treatment, or surgery, I authorize the veterinarians of Midtown Vet Hospital, and their support staff to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

____

Signature of Responsible Party

FOR TECHNICIAN USE ONLY:

AGE:
ATTITUDE:
BP/CUFF/LIMB:
CURRENT MEDS:
DIET (TYPE/FREQ):
HEART RATE:
PULSE:
RESP RATE:

TEMPERATURE:
CHANGE IN DIET?:
BOARD/DAYCARE?:
CURRENT MEDS:

OTHER NOTES:

____
____
____
____
____
____