



## Surgery Check-In

<b>Patient History</b>	<b>Yes</b>	<b>No</b>
1. Has your pet had any medications in the past 72 hours? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
2. Is your pet allergic to any medications? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your pet experienced any trauma in the past 12 months (i.e. stepped on, hit by car, fallen off porch, slammed in door, fights, etc.)? If yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your pet eaten in the past 12 hours?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your pet experienced any dramatic weight loss/gain in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your pet been coughing, wheezing or sneezing?	<input type="checkbox"/>	<input type="checkbox"/>

### Exam Checklist (office use only)

1. Mouth/teeth	<input type="checkbox"/> WNL	<input type="checkbox"/> Baby teeth	<input type="checkbox"/> Broken	<input type="checkbox"/> Calculus	<input type="checkbox"/> Other
2. Eyes	<input type="checkbox"/> WNL	<input type="checkbox"/> Red	<input type="checkbox"/> Discharge	<input type="checkbox"/> Other	
3. Ears	<input type="checkbox"/> WNL	<input type="checkbox"/> Red	<input type="checkbox"/> Discharge	<input type="checkbox"/> Other	
4. Skin	<input type="checkbox"/> WNL	<input type="checkbox"/> Red	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Fleas/ticks	<input type="checkbox"/> Dry/itching
5. Genitals	<input type="checkbox"/> WNL	<input type="checkbox"/> Swollen	<input type="checkbox"/> Discharge	<input type="checkbox"/> Other	
6. Heart/lungs	<input type="checkbox"/> WNL	<input type="checkbox"/> Needs evaluation			

### Other Services Desired While Patient Is Sedated

1. Microchipping	<input type="checkbox"/>	6. Ear Cleaning	<input type="checkbox"/>
2. Dental cleaning	<input type="checkbox"/>	7. Pluck Ear Hair	<input type="checkbox"/>
3. X-rays	<input type="checkbox"/>	8. Express anal glands	<input type="checkbox"/>
4. Growth Removal	<input type="checkbox"/>	9. Sanitary Clip	<input type="checkbox"/>
5. Baby Teeth Extraction(s)	<input type="checkbox"/>	10. Other	<input type="checkbox"/>