

# Veterinary exam form CAT



Examination requested by  owner  insurance company  other For reason  Insurance  Sale/transfer of ownership  Other

OWNER	Name	Phone/mobile phone
	Street name and no	Zip-code, town, country

DESCRIPTION OF CAT	Name of the cat	Date of birth	Sex <input type="checkbox"/> hane <input type="checkbox"/> hona	Neutered <input type="checkbox"/>
	Breed	Colour/pattern		
	Reg.no	ID-number		

CLINICAL OBSERVATIONS	<b>1</b> General condition, body condition, size	<b>2</b> Disposition	<b>3</b> Skin, paws/claws	<b>4</b> Palpable lymph nodes	<b>5</b> Eyes	<b>6</b> Ears	<b>7</b> Mouth, teeth, throat
	<b>General condition</b> <input type="checkbox"/> Lowered condition <b>Body condition, size</b> <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Reserved <input type="checkbox"/> Scared <input type="checkbox"/> Aggressive  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<b>Skin</b> <input type="checkbox"/> Rash <input type="checkbox"/> Dandruff <input type="checkbox"/> Vermin <input type="checkbox"/> Itching <b>Paws/claws</b> <input type="checkbox"/> Changes  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Enlarged all over <input type="checkbox"/> Locally enlarged  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Entropion <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Ektropion <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Corneal injury <input type="checkbox"/> Left <input type="checkbox"/> Right  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Otitis <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Acute <input type="checkbox"/> Chronic  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Tartar <input type="checkbox"/> Tooth fracture <input type="checkbox"/> Gingivitis <input type="checkbox"/> Throat not examined  <input type="checkbox"/> Other <input type="checkbox"/> No remark
	<b>8</b> Abdominal organs, abdominal palpation	<b>9</b> Circulatory system	<b>10</b> Respiratory system	<b>11</b> Outer genital organs	<b>12</b> Locomotion		
<input type="checkbox"/> Umbilical hernia <input type="checkbox"/> Inguinal hernia <input type="checkbox"/> Enlarged prostate  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Murmur <input type="checkbox"/> Signs of heart failure  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Nasal discharge <input type="checkbox"/> Noise at auscultation  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Cryptorchid <input type="checkbox"/> Abnormal testicle size <input type="checkbox"/> Discharge <input type="checkbox"/> Mammary tumor  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Lameness <input type="checkbox"/> Movement disorder <input type="checkbox"/> Muscle atrophy  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Soreness in flexion/extension of <input type="checkbox"/> Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Elbow <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Hip <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other joints <input type="checkbox"/> Left <input type="checkbox"/> Right  <input type="checkbox"/> Other <input type="checkbox"/> No remark	<input type="checkbox"/> Soreness during palpation of back <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Patella luxation <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Kinked tail <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Tail defect <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Other <input type="checkbox"/> No remark	
Explanation for remarks above							

GENERAL STATEMENT	
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## Signed

Valid 7 days after issuance

Place	Veterinarian
Date	