

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"/> male <input type="checkbox"/> female	Neutered <input type="checkbox"/>
	Breed	Colour/pattern		
	Reg.no	ID-number		

CLINICAL OBSERVATIONS	1 General condition, body condition, size <input type="checkbox"/> Lowered condition Body condition, size <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Other <input type="checkbox"/> No remark	2 Disposition <input type="checkbox"/> Reserved <input type="checkbox"/> Scared <input type="checkbox"/> Aggressive <input type="checkbox"/> Other <input type="checkbox"/> No remark	3 Skin, paws/claws Skin <input type="checkbox"/> Rash <input type="checkbox"/> Dandruff <input type="checkbox"/> Vermin <input type="checkbox"/> Itching Paws/claws <input type="checkbox"/> Changes <input type="checkbox"/> Other <input type="checkbox"/> No remark	4 Palpable lymph nodes <input type="checkbox"/> Enlarged all over <input type="checkbox"/> Locally enlarged <input type="checkbox"/> Other <input type="checkbox"/> No remark	5 Eyes <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	6 Ears <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	7 Mouth, teeth, throat <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
	8 Abdominal organs, abdominal palpation <input type="checkbox"/> Umbilical hernia <input type="checkbox"/> Inguinal hernia <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Other <input type="checkbox"/> No remark	9 Circulatory system <input type="checkbox"/> Murmur <input type="checkbox"/> Signs of heart failure <input type="checkbox"/> Other <input type="checkbox"/> No remark	10 Respiratory system <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Noise at auscultation <input type="checkbox"/> Other <input type="checkbox"/> No remark	11 Outer genital organs <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	12 Locomotion <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		