Information about your plans to breed your female:

Your name: _____ Your pet's name: _____
Co-owners names: _____ Your pet's registered name: _____
Registration #_____ DNA completed Y/N _____
Do you have an appointment scheduled? Yes/No Do you want an appointment? Yes/No
What are your preferred appointment dates? Monday/Tuesday/Wednesday/Thursday/Friday/Saturday
What are your preferred appointment times? Early AM/Late AM/ Noon hour/ Early PM/ Late PM
Best way to reach you? Phone (list times available and numbers) _____ (home)
_____ (cell) _____ (work) E mail _____
Have we seen you as a client before? Yes/No Have we seen this pet before? Yes/ No When? _____
Pet Information: Age: _____ weeks/months/years or Date of Birth _____
Dog/Cat Breed: _____ Sex: Male/Neutered/Female/Spayed

Breeding Plan:

Is she is season now? Yes/ No Date this cycle began: _____ Is AI being done at our clinic? Y/N
Type of insemination planned: Natural /Vaginal #_____/ TCI # _____/ Surgical
Type of semen planning to use: Fresh/Fresh Chilled/ Frozen
Date of last Brucella test_____ Test run – RSAT/Culture Vaginal culture? _____
Name of Owner/Stud dog/Bitch to be bred to_____
Location of stud dog's Veterinarian _____ Phone _____
SHIPPING ADDRESS_____
BILLING ADDRESS_____
Shipping plan: UPS/FedEx/ Post office/other SHIPPING BOX PROVIDED BY Shipping vet/client

History:

FEMALE: Date of last cycle _____ First breeding? Yes/ No
Date previously bred on _____ Natural/ AI/ TCI/ Surgical Outcome_____
Timing: None/Male/Vaginal cytology /Progesterone_____
Evaluated on palpation/ultrasound/x-ray Stud dog proven? Yes/ No/ Evaluated? _____
Has your pet been thyroid tested: Yes/ No Results? _____ Date_____
Other previous diagnostics or treatments? _____
Lifestyle: Indoor/ Outdoor Companion dog/ Performance dog/ Breeding dog/ Service dog
Describe her housing and lifestyle: _____
Has she had her health screenings done: OFA/ CERF / Other _____
Does your pet have any allergies to food, vaccines, or medications? No/ Yes
If yes, please describe: _____
Does your pet travel? In state? Out of state? Board? Dog events? Location: _____
Describe your pet's normal diet including treats and table food _____
_____
List of supplements given: _____
_____

*WORMING HISTORY:*Y/N product and dates: _____
VACCINATION HISTORY: Current/None/due for DHLPP on_____/RABIES due on _____

What medications have you given your pet in the past month? Please include over-the-counter medications as well as heartworm preventive and flea/tick control products.

_____

Is there testing or x-rays from a previous illness or injury? Yes/ No _____
Is your pet current on vaccinations and worming/fecal examinations? Yes/No
Do you have pet health insurance? No/ Yes Name of provider? _____
Does your pet need any testing done or medications refilled?

_____
May we request records from your previous veterinarian? Yes/ No
Name of your previous veterinarian? _____ Phone? _____
Do you want a referral letter sent to your local veterinarian? Yes/ No Name: _____

Symptoms:

Do you have any concerns about your pet's health? No/Yes IF yes, please review below:
Describe your pet's overall health:_____
When was your pet last normal? _____
What symptoms have you noticed? _____
What symptoms did you notice first? And how long ago? _____
Are the symptoms getting better/ worse/ staying the same?
Has your pet been treated for this condition in the past? Describe medications and responses:

_____
Is your pet acting normally? Yes/No If no, please describe: _____
Is your pet drinking normally? Yes/ No If no, please describe: _____
Is your pet eating normally? Yes/ No If no, please describe:_____
Is your pet urinating normally? Yes/ No If no, please describe:_____
Is your pet vomiting? Yes/ No If yes, please describe: _____
Is your pet having normal stools? Yes/ No If no, please describe: _____
Has your pet's weight increased/ decreased/ stayed the same?
Is your pet's breathing normally? Yes/ No If no, please describe: _____
Are the eyes normal? Yes/ No If no, please describe: _____
Are the ears normal? Yes/No If no, please describe: _____
What medications have you used? _____
Is the skin normal? Yes/ No If no, please describe:_____
Are there any lumps? Yes/ No Where are the sores, hair loss, or lumps? _____
Are there any abnormalities with the legs, neck or back? Yes/ No If yes, please describe: _____
Do you have any behavior concerns? Yes/No : Please describe _____
Are the reproductive organs normal? Yes/ No
If spayed or neutered, age done? _____
If not spayed, when was her last heat? _____
Plans to breed: _____
Are there observations or concerns we did not include in the questions above?

_____

Client ID _____ Date _____ Staff initials _____ Dr. _____