



**Nordahl Pet Clinic**  
630 Nordahl Rd #L  
San Marcos, CA 92069  
Phone: (760) 738-7399  
Fax: (760) 745-1108  
Nordahlpetclinic.com

Client/ Patient Info Sheet

Owner: \_\_\_\_\_ Owners D.O.B: \_\_\_\_\_ Spouse/ Partner \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ [Receive notifications through Petdesk]

Home Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_ Cell Phone(\_\_\_\_)\_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_

Alternate Contact (Relationship to you): \_\_\_\_\_

Driver's License number/ State \_\_\_\_\_ Driver's License Expiration Date: \_\_\_\_\_

**(California State law mandates that license info is provided in order to verify the owner is 18 years or older in order to prescribe controlled medications.)**

1) Name of Pet: \_\_\_\_\_ Dog \_\_\_\_\_ Cat \_\_\_\_\_ Breed \_\_\_\_\_  
Color: \_\_\_\_\_ Birthday: \_\_\_\_\_ Gender: \_\_\_\_\_ Spayed/Neutered? \_\_\_\_\_  
Vaccine History: \_\_\_\_\_  
Current Medication: \_\_\_\_\_  
Current health or behavioral issues: \_\_\_\_\_  
Microchip Number: \_\_\_\_\_

2) Name of Pet: \_\_\_\_\_ Dog \_\_\_\_\_ Cat \_\_\_\_\_ Breed \_\_\_\_\_  
Color: \_\_\_\_\_ Birthday: \_\_\_\_\_ Gender: \_\_\_\_\_ Spayed/Neutered? \_\_\_\_\_  
Vaccine History: \_\_\_\_\_  
Current Medication: \_\_\_\_\_  
Current health or behavioral issues: \_\_\_\_\_  
Microchip Number: \_\_\_\_\_

**I hereby authorize the veterinarian to examine, prescribe for, treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.**

Signature of Owner: \_\_\_\_\_ Date: \_\_\_\_\_

AVERAGE EXAM TIME: 1 HOUR (SUBJECT TO CHANGE WITH TREATMENT, MEDICATIONS, LABS)

**\*\* Exam held via phone \*\***

**Nordahl Pet Clinic Pre exam notes**

**Date** \_\_\_\_\_

**Client Name** \_\_\_\_\_

**Contact Number** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Pet's Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Car make and color** \_\_\_\_\_

**Species** \_\_\_\_\_ **Breed** \_\_\_\_\_ **Color** \_\_\_\_\_ **Gender** *F/M* Spayed/Neutered Y/N

**Vaccine(VX) up to date?** circle Yes / No **History of VX reaction** Yes/No **Allergens** Yes/No

**Present complaints/Comments/Reason for exam:**

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**Has your pet been vomiting recently?** circle Yes / No

If yes, when it started? \_\_\_\_\_ How long it last \_\_\_\_\_

Frequency roughly \_\_\_\_\_

**Has your pet had diarrhea recently?** circle Yes / No

If yes, when it started? \_\_\_\_\_ How long it last \_\_\_\_\_

Frequency roughly \_\_\_\_\_

**Has your pet been coughing recently?** circle Yes / No

If yes, when it started? \_\_\_\_\_ How long it last \_\_\_\_\_

Frequency roughly \_\_\_\_\_

**Has your pet been sneezing recently?** circle Yes / No

If yes, when it started? \_\_\_\_\_ How long it last \_\_\_\_\_

Frequency roughly \_\_\_\_\_

**How is your pet's appetite?** circle Good/ Less/ None

If less or none : when it started? \_\_\_\_\_ how long it last \_\_\_\_\_

**How's your pet's energy now?** circle Good/ Less/ lethargic

**What kind of medication is your pet currently on?** \_\_\_\_\_

*\*Done by Official Only\**

Weight \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

**\*\*Examen Por El Telefono \*\***

**Notas Para El Doctor**

**Nombre de cliente:** \_\_\_\_\_ **Numero de contacto:** \_\_\_\_\_

**Color y marca de su coche:** \_\_\_\_\_

**Nombre de mascota:** \_\_\_\_\_ **Edad:** \_\_\_\_\_

**Especies:** \_\_\_\_\_ **Raza:** \_\_\_\_\_ **Color:** \_\_\_\_\_ **Genero:** H/M **Esterilizado/a:** Si/No

**Vacuna actualizada:** Si/No **A tenido reaction a las vacunas** Si/ No **Alergias:** Si/ No

¿Cuál es la razón por la que viene?

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¿Su mascota ha estado vomitando recientemente? Sí / No

¿Cuándo empezó? \_\_\_\_\_ ¿Cuánto tiempo duró? \_\_\_\_\_

¿Su mascota ha tenido diarrea recientemente? Si/ No

¿Cuándo empezó? \_\_\_\_\_ ¿Cuánto tiempo duró? \_\_\_\_\_

¿Su mascota ha estado tosiendo recientemente? Si/ No

¿Cuándo empezó? \_\_\_\_\_ ¿Cuánto tiempo duró? \_\_\_\_\_

¿Su mascota ha estado estornudando recientemente? Si/ No \_\_\_\_\_

¿Cuándo empezó? \_\_\_\_\_ ¿Cuánto tiempo duró? \_\_\_\_\_

¿Cómo es el apetito de su mascota? \_\_\_\_\_

¿Cómo es la energía de su mascota? \_\_\_\_\_

¿Qual tipo de medicina está tomando su mascota?

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**\*Hecho por oficial solamente\***

**Peso:** \_\_\_\_\_ **T** \_\_\_\_\_ **P** \_\_\_\_\_ **R** \_\_\_\_\_