



Submit this completed form using one of the methods below:

Fax: 866-332-3994

Email: medicalrecords@petinsurance.com (include your policy # in subject line)

Mail: P.O. Box 183143, Columbus, OH 43218-3143

Direct Inquiries to DVM Insurance Agency • 800-540-2016 • petinsurance.com

Underwritten by: Veterinary Pet Insurance Company* (CA), National Casualty Company (Nat'l)

Physical Examination Record

In an effort to provide you and your pet with exceptional coverage and affordable premiums, we require that all pets lacking a medical history receive a complete physical examination and provide details of any known prior history. During the exam, your veterinarian may make recommendations for testing or care.

Policy Number _____

Pet Owner Last Name _____ First Name _____

Pet Name _____ Pet's Date of Birth ____/____/____

Sex: ☐ M ☐ F Spayed/Neutered: ☐ Yes ☐ No Breed _____ Color _____

Please have your veterinarian complete the form below.

History: Include all known previous and current conditions and treatments. Document all clinical signs and symptoms with their duration, such as coughing, sneezing, vomiting, diarrhea, changes in urination, water consumption, appetite, weight loss, lameness (specify limb(s)), and behavioral or neurological changes.

Also, include any diagnosed or tentatively diagnosed conditions (current, past, or historical), chronic conditions, ongoing or intermittent treatments (medications, supplements, dietary management), diagnostic test or imaging results, recommended tests or treatments, and specialist referrals.

Exam findings and assessments: Document all findings in detail, including but not limited to the locations and sizes of any masses (use the attached Mass/Lesion Chart), evidence of skin, ear, or allergy issues, and identification of specific limb(s) involved in mobility issues. Explain all abnormal findings in the appropriate sections below.

General appearance

☐ NRM ☐ ABN (explain) _____

Oral/dental

☐ NRM ☐ ABN (explain) _____ Grade: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Integument

☐ NRM ☐ ABN (explain) _____

Musculoskeletal☐ NRM ☐ ABN (explain) _____**Circulatory**☐ NRM ☐ ABN (explain) _____**Respiratory**☐ NRM ☐ ABN (explain) _____**Digestive/Rectal**☐ NRM ☐ ABN (explain) _____**Urogenital**☐ NRM ☐ ABN (explain) _____**Eyes/Ears**☐ NRM ☐ ABN (explain) _____**Nervous System**☐ NRM ☐ ABN (explain) _____**Lymph Nodes**☐ NRM ☐ ABN (explain) _____**Mucous Membranes**☐ NRM ☐ ABN (explain) _____

Diagnostic Results or Pending Tests (including, but not limited to, any diagnostics recommended or completed):

Plan/Recommendations (including, but not limited to, any diagnostics recommended or completed):

Are vaccinations up to date? ☐ Yes ☐ No

Veterinarian Name _____

Signature _____

Date of Examination ____/____/____

Hospital Name _____

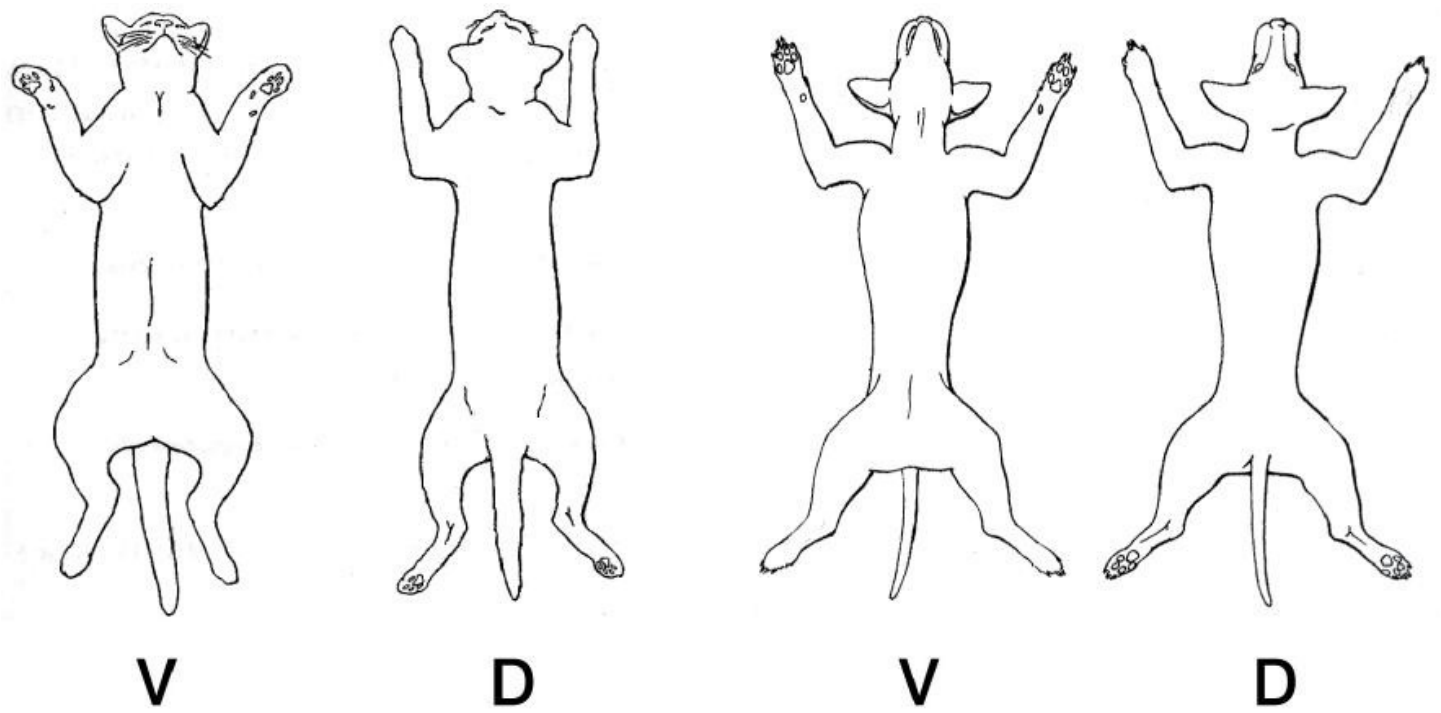
Phone Number _____ Fax Number _____

Email _____

Mass/Lesion Chart

Owner Name _____ Policy Number _____

Pet Name _____ Date ____/____/____



Lesion Number	Date Noted	Size	Date Excised	Cytology/Biopsy Results
1				
2				
3				
4				
5				
6				