Ronald K. Fallon D.V.M.

Practice Limited To Surgery

Patient: ______________________ Name: __________________________ Date: ____________

Contact Phone #: ___________________________ Weight: _______________ Age: ____________

History And Physical Problems

Primary Complaint:

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Side/Limb Affected: Left __________ Right __________ Front __________ Rear __________

When was this first noticed? ____

Has this happened before? ____

How did it happen?

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Medications: ____

Radiographs? ____

Other pertinent information:

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