DROP OFF FORM

Owner:____

Address:____ City/St/Zip:______________________

Home#___________________________ Work#________________________ Cell#_________________

Patient Name:___________________________________ Breed:___________________________________

Color:____ Age:_________________________________

Sex:____ Spayed or Neutered_____________________

The information requested would tell us the things you want us to do for your pet. It is the only way we can be certain that we understand what you want. Therefore, it is very important for you to be as specific as possible. If we need additional information we can reach you at the number you give us today. Thank You.

Reason for drop off:____

Major Complaint?____

When did this issue start?____

Has pet been treated for same condition recently? Yes ( ) No ( )

When and what treatment was preformed?____

Is your pet's condition improved? Yes ( ) No ( )

How has your pet's condition changed?____

____

Dietary and Nutrition:

Current diet?____ Canned ( ) Dry ( )

Number of feedings per day?____________ How much is given at each feeding?____________________

Is your pet's appetite normal? Yes ( ) No ( ) How long?__________________________________

Is your pet given table scraps? Yes( ) No ( ) How often?_________________________________

General Health Questions:

Vomiting? Yes( ) No( ) How long?______________

Diarrhea? Yes( ) No( ) How long?______________

Drinking more or less water than usual? Yes( ) No( ) How long?______________

Urinating more or less than usual? Yes( ) No( ) How long?______________

Weight loss or gain? Yes( ) No( ) How long?_______________

Weakness/Lack of energy? Yes( ) No( ) How long?_______________

Coughing/Sneezing? Yes( ) No( ) How long?_______________

Gagging? Yes( ) No( ) How long?_______________

Scratching? Yes( ) No( ) How long?_______________

Shaking head? Yes( ) No( ) How long?_______________

Limping? Which Leg? Yes( ) No( ) How long?_______________

Scooting? Yes( ) No( ) How long?_______________

History of seizures? Yes( ) No( ) How long?_______________

Bad breath? Yes( ) No( ) How long?_______________

Behavioral changes? Yes( ) No( ) What?__________________

Any known allergies/sensitivities? Yes( ) No( ) What?__________________

Unusual Discharge? From where? Yes( ) No( ) How long?_______________

Unusual lumps or bumps? Yes( ) No( )
Location(s)? Duration_______________________________________

Currently on any medications? Yes( ) No( )
Please list all including dosage and times given:____

____

Supplements given:____

____

Vaccinations:

Are your pet's vaccinations current? Yes( ) No( ) Given here or elsewhere?

Is your pet on heartworm preventive? Yes( ) No( ) What kind?______________

Is your pet on flea preventive? Yes( ) No( ) What kind?______________

Anything else we need to know? Yes( ) No( )________________________________

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Some pets require sedation for adequate physical exam, treatment, surgery or dentistry.
May we sedate your pet if necessary? Yes( ) No( ) Call first( )

After examination by the Doctor, may we proceed with tests and/or treatment? Yes( ) No( ) Call first( )

If we are unable to reach you, I authorize the treatment of my pet as deemed best by the staff Veterinarian, and I assume full responsibility for the treatment expense involved.
Owner/Agent Initial________ Date________________
Call the office by 3:30p.m. to check on your pet's progress in case we have not been able to get in touch with you.

Owner release: The clinic and staff will **Not** be held liable for any problems that develop provided reasonable care and precautions are followed. I undersand that any problem that develops with my pet while I am absent will be treated as deemed best by the Veterinarian and I assume full responsibility for the treatment expense involved.

Owner/Agent____ Date___________________

What is the best phone # to reach you today?______________________________________