Patient Drop-Off History Form

Pet's Name ______________________________ Owner's Name ______________________________________

Contact Number #1 ________________________ Contact Number #2 ___________________________________

The information you provide below will let us know the best way to help your pet. It is important to be as thorough and accurate as possible. Your pet will receive a physical exam today ($52). We will call you to discuss our findings and recommendations.

#1 What is the reason for your pet's visit? ____

#2 Current diet ____________________________________ Amount fed per day ________________________

#3 Did your pet eat today? YES NO

#4 Please list any medications your pet is taking (including prescription/over the counter/supplements/flea and heartworm control)

_________________________ ___________________________ _____________________________

#5 If your pet is a diabetic, did they receive insulin this morning? YES NO NOT DIABETIC

Type of insulin? _____________ How much insulin? _____________ At what time? ___________________

#6 Is your pet scratching/chewing/licking their skin or shaking their head? YES NO

How long? _______________________

Where are they scratching/chewing/biting? ____

Is it seasonal (few times out of the year) or year round (consistently present)? __________________

#7 Does your pet have any lumps or bumps that you would like addressed today? YES NO

How long have they been present? ____

Is your pet licking or chewing them? YES NO Do they bleed or have pus? YES NO

Are they growing? YES NO Have these masses been looked at by another vet or us? YES NO

#8 Is your pet limping? YES NO For how long? ____________________ On what leg? _________________

Is it all the time or occasional? ___________________________ When is it the worst? __________________________

Symptom	YES or NO (Please Circle One)	IF YES, PLEASE CHECK ALL RELEVANT WORDS OR PHRASES
Change in appetite?	YES NO	Not eating at all ( ) Decreased appetite ( ) Will only eat treats ( ) Increased appetite ( )
Change in drinking?	YES NO	Increased ( ) Decreased ( ) Not drinking at all ( )
Vomiting?	YES NO	Vomiting white foam ( ) Vomiting yellow/green fluid ( ) Blood in vomit ( ) Vomiting food ( ) Got into trash ( ) Fed table scraps recently ( ) Any history of eating toys/ string/ clothing ( )
Diarrhea?	YES NO	Watery/runny stool ( ) Soft but formed stool ( ) Soft stool with no form to it ( ) Blood in stool ( ) Mucous or slime in stool ( )
Change in urination?	YES NO	Blood in urine ( ) Increase frequency ( ) Smaller amounts ( ) Urinating in the house ( ) Crying when urinating ( ) Urinating while asleep ( ) Licking vulva or penis ( )
Coughing?	YES NO	Moist cough ( ) Dry cough ( ) Occurs at night ( ) Occurs during day ( ) Associated with activity ( ) Associated with barking ( ) Associated with drinking water ( )

Sneezing?	YES NO	Increased frequency ( ) Mucoid nasal discharge ( ) Clear nasal discharge ( ) Watery eyes ( )

Additional services requested and authorized to be performed today:

Ear cleaning ( ) Fecal exam ( ) Place a microchip ( )

Heartworm test ( ) Nail trim ( ) Vaccines ( )

Express Anal Glands ( )

While your pet is here, does he/she need any prescription refills? ____

Please read and initial the following:

_____ I understand the doctor will contact me after my pet has been examined to discuss findings and a treatment plan and/or further testing.

_____ I understand the doctor will be unable to proceed with any plans until she has spoken directly to me and I have authorized the treatment plan/tests and the charges associated with them.

_____ Payment is due at the time of discharge. I understand follow up exams and treatments are not included in today's charges.

_____ All pets staying in the hospital must have current vaccines unless medically contraindicated.

Please choose one of the following:

( ) I DO authorize the staff, in an emergency situation, to perform any procedures necessary for the well-being of my pet until further communication with me. I will be responsible for any additional charges.

( ) I DO NOT authorize the staff, in an emergency situation, to perform any unauthorized procedures without contacting me first.

Signature of Owner ____ Date __________________________

OFFICE USE ONLY

Admitted by: _______________________

Carrier or leash left with pet? YES NO

Meds left with patient? YES NO

Vaccines Current: YES NO UPDATE TODAY