PATIENT DROP OFF SHEET

While an examination of a pet with the owner present is always preferred, we realize that sometimes this is not possible. To aid us in helping your pet, please take a few moments to give us some important information.

A) CLIENT NAME_____ **DATE**_____

Phone (Daytime):_____ ***Alternative:***_____

B) PET'S NAME_____

C) CHIEF COMPLAINT/CONCERN:_____

D) SYMPTOMS: (circle those that apply)

1. APPETITE: *increased same decreased Duration?*_____

2. WATER CONSUMPTION: *increased same decreased Duration?*_____

3. BOWEL HABITS: *diarrhea constipated normal Duration?*_____

4. URINATION: *increased same decreased Duration?*_____

5. VOMITTING? *COUGHING? SNEEZING? Duration?*_____

6. ITCHING? EXCESSIVE SCRATCHING, CHEWING, OR GROOMING BEHAVIOR?

*Yes No Where?*_____

E) HUSBANDRY:

1. *Indoor Only Indoor Mostly Indoor/Outdoor Outdoor Mostly Outdoor Only*

2. *Diet (type & brand of food)*_____

F) PERTINENT MEDICAL HISTORY:

1. *Are you aware of your pet having allergies or adverse reactions to any drugs?*
*Yes No Type*_____

2. *History of seizures? Yes No*

RELEASE FOR TREATMENT

Would you authorize treatment deemed necessary by the doctor, for example cortisone injections, ear cleaning, antibiotic injections? Yes No

Signature_____ **Date**_____

If you haven't heard from us by 2:30 today, please call to check on your pet.