



Drop off History Form

Please take a moment and answer the following questions so that we can better help your pet.

Pet name:

Client Name:

Everything was okay with my pet until _____. Since then, _____

I think his/her _____ is bothering him/her.

My pet has not eaten since _____ My pet started vomiting: Yes/No When? _____

What color and substance? _____ Last vomited? _____

My pet started having diarrhea Yes/ No When? _____ What color and consistency? _____

Has your pet had access to foods other than their regular pet food? (ex. Rawhides, Salmon, Garbage) _____

Please circle your pet's symptoms:

I feel that this is an emergency: Yes / No

My pet is: lame / sore / injured Please specify: _____

My pet is lethargic: Yes/No

My pet has normal stools Yes/No

My pet has: lost / gained weight

Water intake has: decreased / increased / is unchanged.

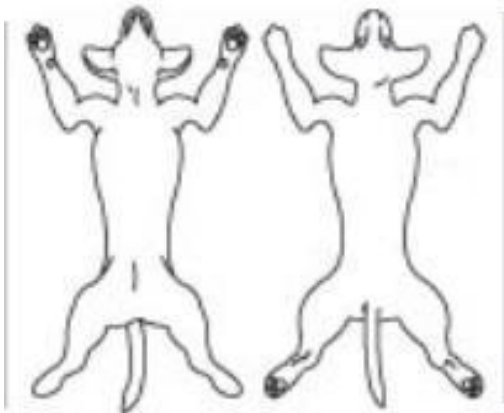
This has: never happened before / recently happened / or is a long time (chronic) problem

My pet is coughing: Yes / No

My pet sneezing or has discharge from eyes or nose: Yes / No

Please list a phone number you can be reached at today _____ Alternate number for contact _____

Circle the part of your pet that hurts:



Sedative/Anesthesia Release

You are to use all responsible means against injury, escape, or death of my pet. I understand that all anesthetics involves some risk to my pet, but you will not be held responsible under any circumstances in connection therewith as it is thoroughly understood that I assume all risks.

I have read this statement and agree.

Owner/Agent _____

Date: _____ Phone: _____

If we find lab work, x-rays, fluid therapy, etc necessary should we wait or proceed pending our phone conversation?

Proceed: _____ Wait: _____