Client Name ________________________________ Patient name ____________________

Surgery/Dental Drop Off Sheet

This form is for us to better assess your pet. Please help us by filling it out completely.

When was your pet's last meal prior to arrival? _____________________________________

Has your pet ever had a seizure? Please explain. ____________________________________
____

Have you noticed a change in any of the following? If yes, check appropriate box and explain on lines provided.

- ❑ Appetite
- ❑ Thirst
- ❑ Energy level
- ❑ Exercise tolerance
- ❑ Breathing
- ❑ Urination/defecation
- ❑ Body condition
- ❑ Other

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Has your pet had any of the following symptoms? If yes, check appropriate box and explain on lines provided.

- ❑ Sneezing
- ❑ Coughing
- ❑ Nose/eye discharge
- ❑ Rapid weight gain
- ❑ Rapid weight loss
- ❑ Vomiting
- ❑ Diarrhea

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Has your pet had any previous problems with anesthesia such as a slow recovery? If yes, please explain. ____
____

Is your pet on any medications? If yes, please list what medications and when the last dose was given. ____
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Signature ____ Date _________________