Patient Drop Off

El Cerrito Veterinary Hospital thanks you for dropping off your pet with us today! The following information will be used to help our veterinary team accurately complete your pet's medical history for today's visit.

Today's Date: ___/____/____

Your name: _____ Pet name: _____

We need to be able to contact someone with the authority to make medical and financial decisions.
Is that you or someone else? ☐ You or ☐ Name_____

1st Phone #_____ 2nd Phone #_____

Reason for visit: (check all that apply)

☐ General Exam
☐ Dental Prophylaxis
☐ Spay or Neuter
☐ X-rays
☐ Ultrasound
☐ Lab work_____
☐ Lump(s) Removal(s)
Where? _____
Would you like biopsy the lump(s)? ☐ Yes ☐ No
☐ Injury _____
☐ Illness _____
☐ Other surgical procedure_____

Are there any other concerns for visit today: (check all that apply)

☐ Weakness	☐ Lethargic	☐ Check Lump(s)	☐ Constipation
☐ Eating	☐ Vomiting	☐ Itching/Scratching	☐ Behavioral
☐ Drinking	☐ Diarrhea	☐ Skin Masses/Lesions	☐ Coughing
☐ Bad Breath	☐ Eyes	☐ Scooting	☐ Limping
☐ Weight Loss	☐ Ears	☐ Shaking Head	☐ Painful
☐ Weight Gain	☐ Urination Issues	☐ Gagging	☐ Nail Trim
☐ Check Lump(s)	☐ Deworm	☐ Anal Glands	☐ FIV/FLV Test
☐ Heartworm Test	☐ Other _____		

Vaccination

☐ Canine Vaccines ☐ Feline Vaccines

Please explain your concerns briefly for our team. How long has this issue persisted? Which leg, eye, or ear? Has eating/drinking increased or decreased? Etc.…Any information is helpful to our team.

_____
_____
_____
_____
_____

When did your pet last eat? _____ ☐ am ☐ pm ☐ Today or ☐ Yesterday

Has your pet ever had an adverse reaction to any medications, vaccines or procedure?
☐ Yes ☐ No *If so, describe* _____

Is your pet taking any medications, supplements, prescription food? ☐ Yes ☐ No
If so what are they? _____
Any refills needed? ☐ Yes ☐ No _____

What is the lifestyle of your pet?
☐ Indoor Only ☐ Indoor/Outdoor ☐ Dog Beach ☐ Dog Park ☐ Hike/Swim