DROP OFF FORM

A critical part of caring for your pet is the history we obtain from you. Please answer ALL of the questions below as **SPECIFICALLY** as possible. The doctor will be relying on your answers to help make your pet better.

Owner Name _____ Pet Name _____Date:_____

****PHONE NUMBERS where you can be reached today. (VERY IMPORTANT – DO NOT LEAVE BLANK)****

(_____)_____and(_____)_____and(_____)_____

1. What is your main reason for bringing your pet in today?_____

_____

*****IT IS EXTREMELY IMPORTANT TO LIST ALL MEDICATIONS THAT YOUR PET IS CURRENTLY GETTING AS WELL AS ANY SUPPLEMENTS. WHAT MEDICATIONS/SUPPLEMENTS ARE YOU CURRENTLY GIVING YOUR PET?**

_____

_____

_____

2. Regarding today's visit:
   a. How long has this been going on? _____
   b. Is the problem getting better or worse? _____
   c. Has this problem ever happened to your pet before?_____ if yes, when _____
   d. What treatment was done? _____
   e. Did your pet respond to the treatment? _____

3. Please **circle** each symptom that applies:
   Vomit: food fluid foam How often? _____
   Diarrhea: soft liquid bloody How Often? _____
   Cough: dry hacking moist **Sneeze:** dry wet
   Eye Discharge: left right both **Nose Discharge**: left right both
   Activity Level: normal decrease increase **Weight:** gain loss
   Lameness – which limb: left front left rear right front right rear

4. Have you noticed any changes in:

	Increase	Decrease	How Long
Appetite	_____	_____	_____
Drinking	_____	_____	_____
Urination	_____	_____	_____

5. Is your pet indoors, outdoors or both? _____

6. When was your pet last bathed? _____

7. What % of your pet's diet is commercial food? _____ Name of brand:_____
   What % is people food? _____

8. Do you have any other pets? No ____ Yes____ Dog(s) ____ Cat(s) _____
   If yes, are any of them similarly affected? No _____ Yes _____

9. Any other information you might feel would be helpful to the doctor: _____
   _____
   _____

SIGNATURE _____ **Date** _____

AUTHORIZATION FOR ANESTHESIA: After the exam we will contact you regarding necessary further testing or treatment. If sedation is required we will contact you but will need a signature on file.

Please initial if you authorize sedation _____.