DROP-OFF INFORMATION SHEET

Patient's Name:
Client's Name:
Date:

Reason for today's visit:

_____

_____

When did your pet develop this problem?

_____

_____

Describe the sequence of events since that time:

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Is Your Pet:

1. Eating? *YES / NO*

    If "NO", please indicate date and time of last meal -

2. Vomiting? *YES / NO.*

    If "YES", how many times? _____

    When was the last episode? _____

3. Showing lethargy or depression? *YES / NO*

4. Having diarrhea? *YES / NO*

    If "YES", how many times? _____

    When was the last episode? _____

5. Sneezing? *YES / NO*

6. Coughing? *YES / NO*

7. Gagging? *YES / NO*

8. Limping? *YES / NO*

If "YES", which limb?

_____

9. Scratching? *YES / NO*

If "YES", where?

_____

10. Having difficulty urinating? *YES / NO*

11. Difficulty defecating? *YES / NO*

12. Head shaking? *YES / NO*

13. Smelling badly? *YES / NO*

14. Having any discharge from the eyes? *YES / NO*

If "YES", which eye? _____

15. Having any discharge from the nose? *YES / NO*

16. Experiencing any bleeding? *YES / NO*

If "YES" where? _____

If needed, do you authorize the following services?

1. Treatment of your pet's problem(s)? *YES / NO*

2. Sedation or anesthesia for examination or treatment? (If necessary) *YES / NO*

3. Blood tests? *YES / NO*

4. Radiographs (x-rays)? *YES / NO*

5. Other diagnostics? *YES / NO*

Primary Contact	
Secondary Contact	

***SIGNATURE*_____**

(Owner or Authorized Agent)