PATIENT DROP-OFF SHEET

Please answer all questions with: Yes, No or Not Applicable (N/A).

Owner's Name:____________________________

Telephone numbers where you may be reached today:

1)____________________ 3)____________________

2)____________________ 4)____________________

Pet's Name:______________ Age:__________ Male:______ Female:______

Neutered/Spayed: Yes: _____ No: _____ When? ______________

Describe the current Problem: ____________________________

____

____

____

When was the problem first noticed?____________________________

Has your pet's condition improved or worsened? (Please explain)____________________

____

Has your pet had any previous health problems? Yes:_____ No:_____

If yes when? What was the nature of the problem(s):____________________

____

At what other veterinary clinic(s) has your pet been seen or treated most recently?

____

May we request a faxed copy of your pet's veterinary medical information from your pet's previous veterinarian(s)? Yes: ___ No: ___

Is your pet currently receiving any medication (including Heartworm prevention)?

Yes:_____ No:_____ If yes, What medication(s)? **Name and dosage if known:**

____

When was the medication last given?____________________________

Is your pet allergic to any medications or vaccines? Yes: _____ No: _____

If yes, what medications or vaccines?____________________________

Owners Signature:____________________________

Your pet will be thoroughly examined and evaluated. A Doctor or staff member will call you with information on required treatments and medication for your pet as well as an estimate of related costs as soon as possible.