

PATIENT DROP-OFF SHEET

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

Owner's Name: _____ Today's Date: _____

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.