Patient Drop Off & Additional Services Sheet

Thank 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 will need to be able to contact you or someone with permission to make medical and financial decisions.

Who will we be speaking with? ☐ Me or ☐ Name _____

1st phone _____ **2nd phone** _____

Reason for visit *(check all that apply)*

☐ Preventive Care	☐ Weight Management / Nutritional Questions
☐ Comprehensive Exam	☐ Other surgical procedure _____
☐ Dental Prophylaxis	☐ Illness _____
☐ Spay or Neuter	☐ Injury _____
☐ Behavioral Questions	_____

Are there any concerns for: *(check all that apply)*

☐ Eating	☐ Weight Gain	☐ Car Sickness	☐ Behavioral Problem
☐ Drinking	☐ Itching/Scratching	☐ Vomiting	☐ Other
☐ Bad Breath	☐ Difficulty Rising	☐ Diarrhea	_____
☐ Excessive Sleeping	☐ Scooting	☐ Skin Masses/Lesions	_____
☐ Weight Loss	☐ Shaking Head	☐ Urination Issues	

Additional comments on reason for visit and concerns: _____

_____

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

Has your pet ever had an adverse reaction to any medications? ☐ No ☐ Yes

If so, describe _____

Has your pet ever had an adverse reaction to vaccines or any procedure? ☐ No ☐ Yes

If so, describe _____

Is your pet ever in pain after vaccines or other procedures? ☐ No ☐ Yes

If so, describe _____

Is your pet taking any medication(s)? ☐ No ☐ Yes

If so, describe _____

Pick up time _____ ☐ am ☐ pm

Any refills needed? _____ ☐ No ☐ Yes