



Drop Off Form and Sick Pet History

Client's Last Name: _____

Patient Name: _____

Telephone Number you can be reached today: _____

When did your pet last eat? _____ Drink? _____

Patient History

Has your pet shown any of the following signs? Check all clinical signs that apply. Please note **when** clinical signs started and/or **how long** have persisted.

- | | |
|--|--|
| <input type="checkbox"/> Vomiting (i.e., food, water, etc.):
_____ | <input type="checkbox"/> Coughing (when and how often):
_____ |
| <input type="checkbox"/> Diarrhea: _____ | <input type="checkbox"/> Sneezing: _____ |
| <input type="checkbox"/> Lethargy: _____ | <input type="checkbox"/> Nasal discharge: _____ |
| <input type="checkbox"/> Loss of appetite: _____ | <input type="checkbox"/> Eye discharge: _____ |
| <input type="checkbox"/> Weight loss or gain: _____ | <input type="checkbox"/> Lameness/Limping-which leg: _____ |
| <input type="checkbox"/> Increase or decrease in drinking
(how long): _____ | <input type="checkbox"/> Scratching/Chewing (where):
_____ |
| <input type="checkbox"/> Increase or decrease in urination:
(how long): _____ | <input type="checkbox"/> Scratching/shaking ears? _____ |
| <input type="checkbox"/> Weakness or difficulty rising:
_____ | <input type="checkbox"/> Scooting: _____ |
| | <input type="checkbox"/> Skin growth(Where): _____ |
| | <input type="checkbox"/> Other? _____ |

Is it OK to sedate your pet for procedures if necessary? Yes No

Is your pet on any other medications other than heartworm/flea products? Yes No
If yes, what medications? _____

Signature: _____ Date: _____