Drop Off Information Questionnaire - Please fill in as completely as possible

Owner Name:________________	Pet Name:_______________	Date:_____________	Weight:____________
Address/Phone #/Email Update:____			
Primary Reason for Dropping Off:___________________________		How would you like to be contacted today? **Phone Call or Text Message**	

Dear Pet Parent,
The following questions are very important in order for us to keep up with and better understand your pet's medical history as well as to decide on appropriate treatment. Thank you for helping us care for your special family member.

Has your pet shown any of the following signs or symptoms? If YES, please indicate for how long.

Unusual body odors?	NO YES______________	Head shaking or ear odor?	NO YES______________
Coughing, sneezing, wheezing?	NO YES______________	Itching or scratching?	NO YES______________
Gagging or choking?	NO YES______________	Poor coat or hair loss?	NO YES______________
Vomiting or diarrhea?	NO YES______________	Skin issues?	NO YES______________
Scooting the rear end?	NO YES______________	Unusual discharge?	NO YES______________
Listlessness or weakness?	NO YES______________	Lumps or bumps?	NO YES______________
Red gums or offensive breath?	NO YES______________	Tremors or seizures?	NO YES______________

Has your pet shown a significant change of any of the following? If YES, please indicate for how long.

Character of bowel movements?	NO YES__________	Increase in drinking?	NO YES______________
Frequency or amount of urination?	NO YES__________	Change in behavior?	NO YES______________
Weight gain or loss?	NO YES__________	Difficulty hearing?	NO YES______________
Change in appetite?	NO YES__________	Training behavior problems?	NO YES______________

Has your pet shown any of the following signs of pain? If YES, please indicate for how long.

Lameness in limbs?	NO YES______________	Lethargic?	NO YES______________
Stiffness when getting up?	NO YES______________	Crying or whimpering?	NO YES______________
Hiding in unusual places?	NO YES______________	Food falling out of mouth?	NO YES______________
Uncontrollable shaking?	NO YES______________	Excessive drooling?	NO YES______________
Excessive panting?	NO YES______________	Sensitivity when chewing?	NO YES______________

Where does your pet primarily reside? INSIDE or OUTSIDE
Additional Comments or Question:____
____

Current medications/supplements being given currently: ________________________________
____
____

Refills Needed? YES/NO Which medication(s)?_______________________________________

Current diet:______________________________ **Canned/Dry** **Treats given:**___________________
Last meal:_________________________

When was your pet last vaccinated?_________________________ **Where?**_______________________
When was heart worm prevention last given?____________________
When was flea control last administered?_______________________

Our doctors must be able to reach you today with additional questions and/or discharge information.
1. Phone/Text________________________________ **2. Phone/Text**______________________________

How do you-as owner-want to proceed with treatment today?
☐ Basic diagnostics then contact ☐ Exam only, then contact
☐ What ever doctor deems needed with treatment today. Up to $___________

Forms attached and signed:
☐ Consent to Drop Off Treatment

Signature:____ **Date:**__________________