

Drop Off Information for Sick Patients

Date <date>

Owner: <first-and-spouse> <last-name>
Phone: <area> <phone>

Patient: <animal>
Breed: <breed>
Age: <age> Sex: <sex>

Contact Phone Numbers: _____ (Work / Mobile / Home)

_____ (Work/ Mobile/ Home)

Chief Complaint

What is the primary reason that we are seeing your pet today? _____

Everything was OK with my pet until _____. Since then, _____

Has your pet suffered from this before? Yes No

Food/ Water

Brand or variety of food: _____ Canned Dry

Was your pet offered food today? Yes No

Did your pet eat? Ate Well Ate half Ate a little Not at all

Does your pet regularly receive any other snacks? Yes No

If yes, Pet treats People food

Has your pet recently had access to any other food than its normal diet? Yes No

If yes, please specify: _____

Water intake appears to have: decreased increased stayed the same

Please select appropriate symptoms and clarify where necessary:

Vomiting : Yes No

If yes, when did it start?: _____

Did you observe the vomiting episode? Yes No

Color: _____ Blood? Yes No

Frequency: _____ My pet last vomited: _____

Diarrhea : Yes No

When did the diarrhea start?: _____

Color: _____ Blood? Yes No

Consistency: Soft Watery

Frequency: _____

Respiratory: Yes No

Is your pet coughing or gagging? Yes No

Is anything being produced when your pet does this? Yes No If so, what: _____

Is your pet sneezing or having discharge from the eyes or nose? Yes No

Color: _____

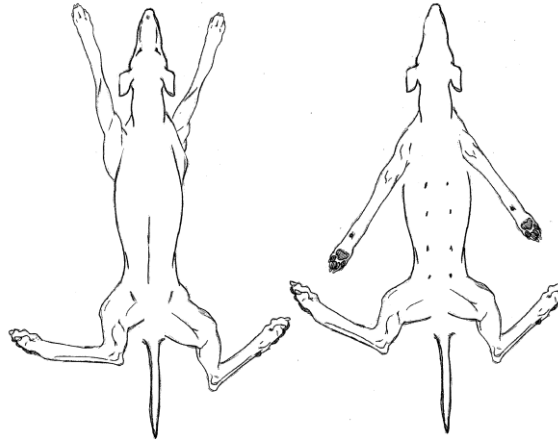
Lameness or Limping: Yes No

My pet is: Lame (non-weight bearing) Limping Sore Has been injured
 Front : Rear: Left: Right:
 When did it start?: _____ It has: worsened remained the same improved some
 This has: Never happened before happened recently Is a long term problem

Lumps, bumps, masses: Yes No

When did you notice the lump?: _____
 It has : Increased in size Decreased in size Remained the same

Please mark the location(s) of the lump(s):



Other Information

Is your pet on any regular medications?: Yes No
 If yes : Prescription from this clinic Prescription from another vet
 OTC Supplement

<i>Medication</i>	<i>Last Given</i>	<i>Amount (Dose)</i>	<i>Frequency (times)</i>

I realize that <animal> must be discharged during office hours. The fee due will be paid in full at that time, unless other arrangements are made with the doctor. In many cases, it is impossible to determine in advance the extent of medical or surgical treatment required, but in such cases an effort will be made to estimate treatment costs. It is understood that the actual cost may exceed this estimate.

If I cannot be reached via telephone numbers listed, I authorize initial diagnostics (including radiographs, sedation, and/or bloodwork) when deemed necessary by the doctor overseeing my pet's case.

Signature: _____ Date: _____