

DROP OFF EXAM ADMISSION

Client _____ Patient _____ Date _____
Phone Number: _____

Describe the problem:

When did it first begin: _____

Has it gotten (please circle): better, worse, or stayed the same since then.

Any (please circle): coughing, sneezing, vomiting, diarrhea, lethargy, not eating.

Any prior treatments: _____

What amount, type, and brand of food does the animal eat? _____

Does the animal eat table scraps? If so, what kind? _____

Do you have any questions for the doctor: _____

Do you need any of the following to go home:

- Heartworm Prevention
- Flea/Tick Prevention
- Food
- Refill of Medications _____

Do we have permission to perform a fecal, bloodwork , x-rays, etc. if necessary? _____

Do we need to call you with an estimate before starting treatment or performing any procedures other than listed above? _____

What time will you be picking up your pet today: _____

CLIENT SIGNATURE: _____