

# DROP OFF QUESTIONNAIRE

Please fill out as completely as possible.

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Telephone # you can be reached at today: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

\_\_\_\_\_

How long has your pet had this problem? \_\_\_\_\_

Is your pet taking any medications (including over the counter medication and supplements)? YES NO

If yes, what medications and how often to you give them? \_\_\_\_\_

\_\_\_\_\_

Is your pet allergic to any medications? YES NO

If yes, what are they? \_\_\_\_\_

What type of food does your pet eat? \_\_\_\_\_

Is your pet.....

Weak or lethargic?	Yes	No	Passing worms in stool?	Yes	No		
Eating?	Less	More	Normally	Drinking?	Less	More	Normally
Constipated?	Yes	No	Having Diarrhea?	Yes	No		
Vomiting?	Yes	No	Coughing?	Yes	No		
Sneezing?	Yes	No	Losing Weight?	Yes	No		
Gaining Weight?	Yes	No	Limping?	Yes	No		
Itching / Scratching?	Yes	No	Lumps?	Yes	No		

If so, where? \_\_\_\_\_ Is so, where? \_\_\_\_\_

Is your pet on a monthly flea control product? Yes No Product: \_\_\_\_\_

Is your pet on a monthly heartworm product? Yes No Product: \_\_\_\_\_

Please select one:  Please call with an estimate

I authorize diagnostics and treatment up to:  \$100  \$200  \$300  \$400

Notes for the veterinarian:

Client Signature: \_\_\_\_\_ Requested pick up time? \_\_\_\_\_