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?_____