Client #: _____

Patient Appointment Form

The most important aspect of the drop-off service is the history provided by the client. Please take the time to fill out this form completely. This questionnaire allows the owner to provide information we commonly need to help our patients. Since our patients cannot talk, the information you provide will hopefully allow us to avoid delays in treatment and unnecessary or expensive testing.

Pet's Name: _____ Date: _____

Owner's Name: _____ (please limit to **one** person)

Phone Number: _____ (please limit to one number)

Reasons for today's visit: _____

Please select any that apply to your pet and explain on provided comment line:

Vomiting? Choose One Bile ☐ Food ☐ Mucus ☐ Blood ☐ Foreign Material ☐ For how long?

Diarrhea? Choose One Blood ☐ Mucus ☐ For how long?

Constipated? Choose One For how long?

Coughing? Choose One Choose One Choose One For how long?

Sneezing? Choose One Discharge: Choose One For how long?

Lethargy? Choose One Scale: 1 (normal) – 10 (severe) Choose One For how long?

Appetite? Choose One Any change in diet? Choose One For how long?

Thirst? Choose One For how long?

Urination? Choose One Discoloration ☐ Straining ☐ For how long?

Limping? Choose One Choose One Choose One Sudden in onset? Choose O For how long?

Skin problems? Choose One Bumps ☐ Redness ☐ Itch ☐ For how long?

Ear problems? Choose One Shaking ☐ Redness ☐ Discharge ☐ Odor ☐ For how long?

Eye problems? Choose One Squinting ☐ Discharge ☐ Color ☐ For how long?

When did your pet last eat? _____

Have they eaten anything they shouldn't have? What? When? _____

Please add comments from above and/or give other pertinent information:

_____

_____

Please list **ALL** medications / supplements your pet is taking:

_____