Patient drop off and additional services sheet

Date:_____

Name of Patient:_____

Reason for visit (check all that apply)

	Preventive care		Comprehensive exam
	Dental Cleaning		Spay or neuter
	Behavioral consultation		Weight management/nutritional consultation
	Illness		
	Injury		

1. Are there any concerns for: (check or circle all that apply)

		Note (date of onset, duration, and description)			Note (date of onset, duration, and description)
	Eating			Shaking Head	
	Tremor (Shaking)			Scooting(Rear on floor)	
	Bad breath			Itching/scratching	
	Excessive sleeping			Difficulty Rising(up and down stairs)	
	Weight loss			Weight gain	
	Eye problem			Drinking	Increase Decrease
	Skin masses/lesions (open sores/cuts)			Urination	Increase Decrease
	Limping	L, R, Front, Back, How long? _____ Any previous surgery?		Diarrhea/ Vomiting/ Both	How often?_____/Day Color?_____ Any blood?_____
	Behavioral problem			Sneezing	
	Ear problem			Coughing	
	Is your pet has any sickness before?				

2. When did your pet last eat? If so, describe
   Have you changed your pet's diet recently? What type of diet?

_____

3. Has your pet ever had an adverse reaction to any medications? If so, describe

_____

4. If your pet ever in pain after vaccines or other procedure? If so, describe

_____

5. Is your pet taking any medications?

_____