Warrensburg Animal Hospital

Drop Off Form

For Clinic Use:

Weight: _____ Temp: _____

Owner Name: _____ Pet Name: _____
Date: _____Best Phone Number For Today_____
Alternative number if unreachable: _____

Reason for Visit: _____
What diet are you feeding (including treats or table foods), How much and how often and when did they last eat?
_____Is your pet indoor, outdoor or both: _____

********** Skin Issues **********

Have you noticed any itching/scratching, licking of the feet or skin growths? YES: ___ NO: ___
Have you noticed your pet scratching at their ears or shaking their head? YES: ___ NO: ___
IF YES WHERE & HOW LONG: _____

********** Respiratory Issues **********

Have you noticed any of the following: SNEEZING ___ COUGHING ___RUNNY NOSE/EYE DISCHARGE ___
IF YES, Specify & How LONG? _____

********** Mobility Issues **********

Have you noticed any limping**?** YES: ___ NO: ___
Does he/she have any trouble getting up, climbing stairs or getting around? YES: ___ NO: ___
IF YES, SPECIFY WHICH LEG(s) & TROUBLES: _____

********** Stomach Issues **********

Has there been any recent vomiting, diarrhea or scooting: YES: ___ NO: ___
Has there been a change in appetite? YES:_____NO: _____
Does the pet have history of eating things they shouldn't (ex: trash, toys) Yes: ____ NO: ____
IF YES, PLEASE SPECIFY: _____

********** Urinary Issues **********

Has there been any change in frequency or amount of urination? YES: ___ NO: ___
Has there been any change in water consumption? INCREASE: ___ DECREASE: ___
If increased, please explain:_____
Has your pet had any accidents in the house? YES: ___ NO: ___ Any difficulty Urinating? _____

Is your Pet allergic to any medications YES: ___ NO: ___ If yes, SPECIFY? _____
Is your pet on any current medications, vitamins, preventatives, supplements? YES: ___ NO: ____
If yes, please list here along with when they last received them: _____
_____
Are there any other concerns that the doctor should know about? _____

Signature: _____ **Date:** _____

Do you give prior authorization for us to perform x-rays or bloodwork if necessary? Yes: ____ No: _____

Payment is expected at time of services rendered. We accept cash, check all major credit cards, Care Credit and ScratchPay. In admitting my pet(s) for treatment I authorize the veterinarians of the clinic and their support staff to administer such treatment and/or perform such diagnostic procedures as deemed necessary.