



Drop Off Treatment Questionnaire

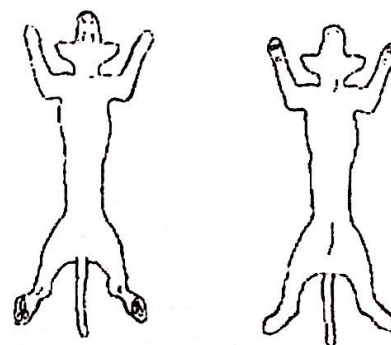
Patient _____ Owner _____ Date _____ Breed _____
Sex M MC F FS Age _____

What will we be seeing your pet for today? _____

Primary Complaints:

- Vomiting Blood in urine Itching Painful Diarrhea Coughing Hairloss
- Growth/Lump Blood in stool Sneezing Lethargic Ears Inappropriate Urination
- Difficulty Breathing Anorexia Eyes Difficulty Urinating Lameness/Limping
- Increased thirst Other: _____

If your pet has any unusual; lumps, bumps, wounds or skin irritation which you would like the doctor to address today, please note the location of each on the body diagram to the right of this page.



Has your pet had an increase or decrease in any of the following: (Please circle one)

- | | | | |
|-------------------|-----------|-----------|-----------|
| Drinking | Increased | Decreased | No Change |
| Appetite | Increased | Decreased | No Change |
| Urination | Increased | Decreased | No Change |
| Defecation | Increased | Decreased | No Change |
| Weight | Increased | Decreased | No Change |

Was your pet fed today? Yes No Time of meal: _____ Date given: _____

Is your pet current on vaccinations? _____

Is your pet on any medications/flea control? (list) _____

What is your pet's diet? _____

Has your pet been seen by another veterinarian for treatment? _____

May we call for records? Yes No If yes, name of clinic? _____

Any other issues you would like addressed? _____

Please read and initial ONE of the following:

- I authorize testing and treatment per estimate given and place no limit on additional charges/services deemed necessary by the veterinarian.
- I authorize testing and treatment per estimate given and approve charges up to an additional \$ _____.
- Please call me with an estimate before performing any procedures not outlined on the estimate given. If I cannot be reached, I authorize additional treatments deemed necessary by the veterinarian.
- Please call me with a revised estimate before performing any additional procedures not outlined on the estimate given. I understand that if I cannot be reached, my pet will receive NO treatments, except in the case of an emergency, other than those outlined on the original estimate.

Please read and initial the following:

I hereby give my consent to Tabor Road Veterinary Hospital to perform an exam and treatment(s).

Signature of Owner/Agent _____ Date _____

Primary Phone Today _____ Preferred Pick-Up Time: _____