Patient Intake/Drop-off Form

Date: _____

PET'S NAME: _____	Home Phone #: _____
CLIENT'S NAME: _____	Cell Phone #: _____
E-MAIL: _____	Work Phone #: _____

NICKNAME: _____	Date of Birth: _____
Briefly describe your pet's reason for visit and duration of stay today: _____ _____ _____ _____	Gender: Male/Female
	Spayed/neutered : ___ Yes ___ No

Your answers to the following questionnaire will help the veterinarian to give your pet the individual attention he/she needs:

Habitat:
___Indoor only (never touches the outdoors)
___Outdoor only
___Mostly indoor
___Mostly outdoor
___In and out freely without much supervision
___Mostly supervised

Activity level:
___ Low
___Moderate
___Active
___Very active

Are vaccines up to date? ___Yes ___No

Is pet spayed/neutered? ___Yes ___No

Has pet been tested for intestinal parasites in the last 6 months? ___Yes ___No

Is pet on flea/tick prevention? ___Yes ___No If yes, which brand?_____
If yes, when was it last given?_____

Is pet on heartworm prevention? ___Yes ___No If yes, which brand?_____
If yes, when was it last given?_____

ANY ALLERGIES TO MEDICATIONS OR FOODS: ___ No ___ Yes, please fill in blanks below:

Medication/food:_____	Reaction:_____ _____
Medication/food:_____	Reaction:_____ _____
Medication/food:_____	Reaction:_____ _____

Current medications/supplements/OTC products/homeopathic remedies,
Drug Name, Dose, Frequency:
_____
_____
_____

Current diet (brand, amount, frequency):
_____
_____
_____

Does your pet get table scraps/people food? ___Yes ___No

Appetite change? ___Yes ___No If yes, please explain:
_____
_____
_____

Change in water consumption? ___Yes ___No If yes, please explain:
_____
_____
_____

Behavioral changes? ___Yes ___No If yes, please explain:
_____
_____
_____

Has pet eaten any toys/chews/trash? ___Yes ___No

Weakness? ___Yes ___No

Painful? ___Yes ___No If yes, for how long?_____

Lameness? ___Yes ___No If yes, which leg?_____

History of seizures? ___Yes ___No If yes, how frequent?_____
When was last known seizure? _____

Scratching? ___Yes ___No If yes, please indicate on scale of 1-10 (1 least, 10

nonstop itching): _____

Lumps or bumps? ___Yes ___No
If yes, has there been a change in size? ___Yes ___No
Are cigarettes/cigars/e-cigarettes used around pet? ___Yes ___No

History of arthritis?	Yes	No	Loss of Hair?	Yes	No
History of fight wounds?	Yes	No	Excessive licking?	Yes	No
Any old injuries?	Yes	No	Chewing on feet?	Yes	No
Vomiting?	Yes	No	Scooting?	Yes	No
Diarrhea?	Yes	No	Sneezing?	Yes	No
Urinating more or less?	Yes	No	Gagging?	Yes	No
Straining to urinate?	Yes	No	Nasal discharge?	Yes	No
Straining to defecate?	Yes	No	Eye discharge?	Yes	No
Accidents in house?	Yes	No	Injury to eye?	Yes	No
Shaking head?	Yes	No			

I authorize Boyd's Creek Animal Hospital to expend up to $ _____ in diagnosis or treatment on my pet as needed. I understand there will be a hospital in-patient charge. Please call if any additional services are recommended.

___ I have received and signed an estimate
___ I have not received or signed an estimate

Signature:_____ Date: _____

Emergency Contact Name:_____ Phone #:_____