Patient Label

Boyd's Creek Animal Hospital
History/Drop-off Form

Drop-off Date and Time:_____

Pick-up Date and Time: _____

Phone number(s): _____

E-mail: _____

Briefly describe your pet's reason for visit:

_____
_____
_____
_____

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

Circle your answer for the following questions:
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: Yes / No
If yes, please fill in blanks below:

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

Continued:
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
Scratching? Yes / No If yes, please indicate on scale of 1-10 (1 least, 10 nonstop itching):_____
Are cigarettes/cigars/e-cigarettes used around pet? Yes / No

Circle any of the following that apply to your pet (select all that apply):

History of arthritis History of fight wounds Any old injuries Vomiting Diarrhea

Urinating more or less Straining to urinate Straining to defecate Accidents in house

Shaking head Loss of Hair Excessive licking Chewing on feet Scooting Sneezing

Gagging Nasal discharge Eye discharge Injury to eye Pain Weakness Seizures

Other concerns:

_____
_____
_____

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: _____

Witness: _____