

DROP-OFF ILLNESS QUESTIONNAIRE

DATE: _____ (Deposit _____ office use only)

PET NAME: _____ OWNER'S NAME: _____

SYMPTOMS (check any that apply)

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decreased eye sight

abdominal pain or swelling

eye or eye lid drainage/redness

scooting or chewing at rectum

decreased hearing

difficult defecation

ear odor, drainage, or pain

itching or scratching (where)

shaking head

skin lumps or bumps (where)

scratching at ears

hair loss or redness of skin (where)

coughing or sneezing

increased body odor

excessive panting

difficulty climbing or rising

mouth/teeth odor/soreness

difficulty or reluctance to jump up

increased or decreased appetite

stiffness or lameness (where)

weight gain or loss

acts painful (where)

increased or decreased thirst

toe nail(s) over grown

increased or difficult urination

decreased activity level

loss of house training

confusion or disorientation

vomiting

decreased responsiveness

abnormal stools

bleeding from any body orifice (where)

For item(s) circled above:

1) How long have symptoms been noticed? _____

2) How often have symptoms been occurring? _____

3) Are symptoms improving, staying the same, or worsening? _____

Is your pet currently on heartworm preventative? _____

Please choose on of the following options.

If needed after the doctor's exam, may we SEDATE, do preliminary bloodwork, urinalysis, and/or X-rays?

_____ Yes, please proceed with whatever testing and treatment is needed.

_____ Yes, please proceed with testing and treatment up to \$_____ dollars without contacting me.

_____ No, I must be contacted before any testing or treatment is performed (other than what I may have already authorized). ** Your pet will NOT receive any (or additional) treatment until we are able to reach you.**

Signature and phone number(s) _____