FAMILY PET CARE DROP OFF ADMISSION

Date: _____ **Owner's Name:** _____
Pet's Name: _____ **Breed:** _____ **Age:** _____ **Color:** _____ **Sex:** _____
Spayed/ Neutered? **YES NO**

Chief Complaint/ Reason for drop-off:

_____

_____

How long have you noticed this problem? _____

Is the problem getting: **Worse? Better? Same?** _____

Please circle any problem(s) below which your pet is currently experiencing:

vomiting **diarrhea** **coughing** **sneezing** **lethargy**

itchy skin **rash** **scratching ears** **shaking head**

increased/decreased appetite (____%)

Other _____

_____

Patient's current diet? (Include all snacks, treats, and table scraps)

_____

_____

When was patient's last meal? _____

Are vaccines up to date? **YES** **NO** If so, when and where were vaccines given?

_____

Note: Hospital policy requires all patients to be up to date on vaccines. If your pet is overdue, we will vaccinate accordingly. If vaccines were given at another hospital, we will call to verify.

Has your dog had a heartworm test within the past year? **YES NO**
Has your cat had a Feline Leukemia/FIV test within the past year? **YES NO**
If yes where and when (if other than at Family Pet Care) _____

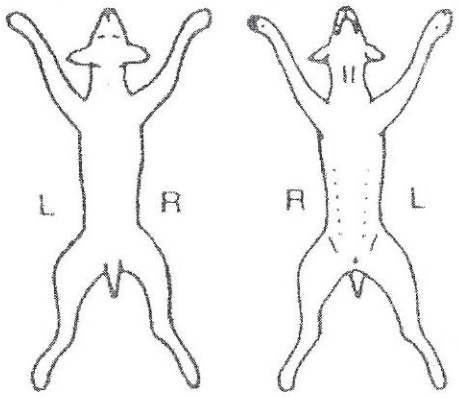
Percentage of time pet spends indoors? _____% Outdoors? _____ %

Current medications? (Include parasite prevention and flea/tick control)

_____

_____

Please circle the affected area of the patient in which you want the doctor to examine specifically:



Top Bottom

Please check ONE option below:

____Please perform any diagnostics/ treatment deemed necessary by the veterinarian.

____Please call with an estimate of recommended services **BEFORE** performing any diagnostics/treatments. If you check this option, we must be able to reach you in order to proceed with the care of your pet.

Any other information we should know?_____

_____

_____

_____

Phone number(s) where you can be reached today?
Home: _____Cell: _____Work: _____Other:_____

_____ _____

Signature of owner or authorized agent Date