Patient Drop Off Form

Animal Medical Center
Kansas City

In Hospital Use: Weight-_____

Date: _____ Pets Name_____

Clients Name: _____ Phone # _____

PLEASE COMPLETELY FILL OUT THE FOLLOWING:

Eating? Y/ N Increased Decreased Normal

Drinking? Y/ N Increased Decreased Normal

Is behavior normal? Y/ N (If NO please explain):

_____

Medications Currently On: _____ Last Given: _____

Up-to-date on Flea/ Tick / Heartworm Prevention? Y/N If a Feline: Indoor/ Outdoor / Both

Reason for Visit (Please select all that apply)

- Itching/Scratching/Licking – Where: _____ How Long: _____
- Shaking Head – How Long: _____
- Urinary Issues – How Long: _____ How Often: _____
  - Inappropriate Urination? Y/ N Where: _____

Blood in Urine? Y/N Increased Urination? Y/N Straining? Y/N Vocalizing? Y/ N

- Oral Issues – What and how long? _____
- Eye Issues – What and how long? _____
- Weight Loss/Gain – When did you notice? _____
- Hard Time Getting Up/Down? How Long: _____

Is your pet experiencing any of the following? Vomiting / Diarrhea / Both

How Many Days: _____ How Often: _____

Within 2 hours of eating? Y / N

Does your pet tend to eat things like socks, toys, blankets, ect? Y/N

If so, what could it be? _____

If a dog, do they go to dog parks, daycare, or grooming? Y/N

Color of vomit: Yellow / Brown / Green / Clear / Black / Undigested

Please Turn Over for Additional Information

Stool Type: Firm / Loose / Liquid Blood Found: Y/N Mucus: Y / N

Has your pet started a new food over the last 2 weeks: Y / N

If so what food were they on vs now: _____

Other Services While Here

Nail Trim	Anal Glands Expressed	Clean Ears	Update Vaccinations

Medication Refill: What Medications? _____

Do we have permission to do the following, IF necessary or recommended by the Veterinarian?

Bloodwork? Y/N Radiographs? Y/N Fecal? Y/N

Ear Swab? Y/N Urinalysis? Y/N

Notes for Doctor: _____

_____

_____

_____

You will be contacted once your pet has been seen by the Veterinarian.

Signature: _____