Patient Drop Off Form

Animal Medical Center
Kansas City

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 – How Long: _____
- ☐ Weight Loss/Gain – When did you notice? _____
- ☐ Hard Time Getting Up/Down? How Long: _____

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: _____