COLONY ANIMAL CLINIC – DROP OFF FORM

OWNER'S NAME:_____ **PET NAME:**_____
WHAT WILL WE BE SEEING YOUR PET FOR TODAY? _____

Please check the significant problems that apply to your pet and prioritize by number

- O Coughing
- O Itching
- O Lethargic
- O Losing weight
- O Vomiting ____ times/day
- O Diarrhea
- O Limping: front rear right left
- O Difficulty urinating
- O Difficulty defecating
- O Eye discharge
- O Nose discharge
- O Sneezing
- O Shaking head
- O Scratching ear(s): right left
- O Having seizures ____times per day/wk/month
- O Other _____

How long has your pet displayed these problems?
_____
_____

Describe your pet's appetite and drinking habits:
_____
_____

Describe your pet's urine and bowel habits:
_____
_____

What are you currently feeding your pet?
Dry food, which brand?_____
Canned food, which brand? _____
People food_____
Is this a recent change? Y / N
If yes, what were you previously feeding? _____
_____

Where does your pet spend his/her time?

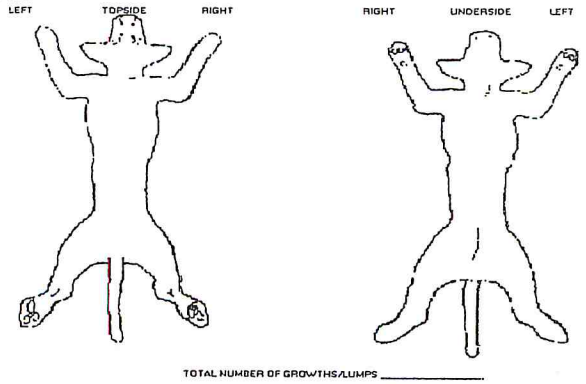
- O Only indoor (never outside)
- O Mainly indoor
- O Mainly outdoor
- O Leash walk neighborhood or visit dog park

Brand heartworm preventative:_____
Date of last dose: _____
Brand flea preventative: _____
Date of last dose:_____

Preferred pick up time: _____ **Signature:** _____

Is your pet currently receiving any other medications?
Please list with daily doses:_____
_____
_____

If your pet has lumps, bumps, cuts, or sores that you wish us to look at, please note the area on the diagram below:



In order to diagnose your pet's condition, your pet may require lab tests, x-rays, and/or other diagnostic testing. Do you authorize tests if the doctor feels it is warranted? Please initial below:
_____Yes, proceed with any doctor recommended diagnostic testing.
_____No, contact me prior to performing any diagnostic testing.

It is very important that we are able to contact you if we have questions regarding your pet. Failure to be reached may result in postponement of treatment. Number(s) where you can be reached today:
_____

Please list any other comments or questions you have for the doctor _____
_____
_____
_____

Please indicate any other services you would like today:

- O Update vaccinations
- O Microchip
- O Trim nails
- O Bathe (includes nails, ears and anal glands)
- O Administer heartworm/flea medication:
  _____
- O Refill medications _____
  _____
- O Other_____

_____**Date**_____