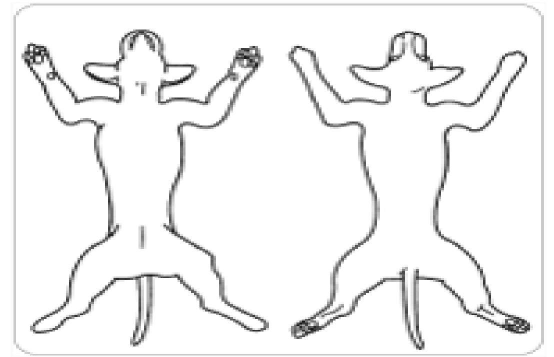
EL DORADO ANIMAL HOSPITAL DROP OFF EXAM QUESTIONNAIRE

Client Name: ____
Address: ____________________________________ **City**: ________________ **State**: ________ **Zip**: _________

Patient Name: ____

Reason for today's visit: ____
____
____
____
____



Has your pet had an increase or decrease in any of the following?
Please circle one:

DRINKING	Increased	Decreased	No Change
APPETITE	Increased	Decreased	No Change
URINATION	Increased	Decreased	No Change
BOWEL MOVEMENTS	Increased	Decreased	No Change
WEIGHT	Increased	Decreased	No Change

Please check any significant problems that apply to your pet:
IMPORTANT: Place time frame next to checked items, Example: 2 days, 2 weeks, 2 months

☐ COUGHING	☐ SHAKING HEAD	☐ INNAPROPRIATE URINATION
☐ ITCHY SKIN	☐ BLOOD IN URINE	☐ HAIRLOSS
☐ SNEEZING	☐ BLOOD IN STOOL	☐ DIFFICULTY URINATING
☐ VOMITING	☐ PAINFUL	☐ GROWTH/LUMP
☐ DIARRHEA	☐ LETHARGIC	☐ LIMPING
☐ SCRATCHING EARS	☐ DIFFICULTY BREATHING	☐ RUNNY OR WATERY EYES

Please list any medications or supplements including preventatives:
____
____
____

Pet food Brand(s): ____
How much food: ____________________________________ How Often: __________________________
Any recent changes to diet? (circle one) YES NO If yes: ____

DROP OFF EXAMS ARE OFFERED FOR YOUR CONVIENANCE. YOUR PET WILL BE EXAMINED WHEN THE DOCTOR'S SCHEDULE ALLOWS (CRITICAL PATIENTS WILL BE EXAMINED IMMEDIATELY). PICK UP TIMES CAN NOT BE GUARANTEED, BUT WE WILL TRY OUR BEST TO ACCOMADATE YOUR SCHEDULE. THANK YOU FOR ALLOWING US CARE FOR YOUR PET TODAY!
IT IS VERY IMPORTANT THAT THE DOCTOR IS ABLE TO CONTACT YOU IF THEY HAVE ANY QUESTIONS REGARDING YOUR PET. PLEASE LIST A PHONE NUMBER THAT YOU CAN BE REACHED AT DURING THE DAY. INNABILITY TO REACH YOU MAY RESULT IN A DELAY OF TREATMENT.

SIGNATURE: ________________________________ PHONE#: ________________________________