North Roswell Veterinary Clinic DROP-OFF INFORMATION

Owner name_____ Pet's Name_____ Date_____

Phone number where you can be reached today: (____)_____
At what times will you be at this number?_____

Would you prefer to talk to a doctor prior to our beginning treatment? YES NO

If we are unable to reach you today, please circle your preference:

Begin tests& treatment Do nothing until notified

Circle Area of Concern For Today's Visit:

Itching/Scratching	Coughing	Vomiting	Difficulty Urinating	Appetite Change ↑ ↓
Fleas	Sneezing	Diarrhea	Excessive Urination	Weight Change ↑ ↓
Licking Feet	Eye Problems	Worms	Difficulty Defecating	Annual Vaccines, Fecal. Htworm
Rash	Ear Problems	Hairballs	Excessive Thirst	Behavioral Problem
Hair Loss	Tooth/Mouth Problems	Lameness	Cuts/ Abscess	Painful Areas

Please describe any other problems or services you would like us to address:_____
_____

_____

How long has this problem been going on?_____
_____

With time? Improved deteriorated unchanged

Is your pet on any medication? Thyroid Antibiotic Seizure

Heartworm Preventative Cortisone (Prednisone)

Other (please describe)

_____

Is your pet allergic to any medications or vaccines? YES NO
Describe_____

Has your pet eaten today? YES NO

Are there any flea control products, heartworm preventative, toothpaste, or brushes, pet food or any other products that you would like us to have ready when you pick up your pet?

_____

Signature_____