DROP OFF EXAM HISTORY

Client Name ______________________________ Pet's Name: ______________________________
Address ______________________________ Species:
Sex: ______________________________

Please describe the symptoms your pet is showing:
____
____
____

When did you first notice the problem?____

Is your pet having any of the following symptoms?

Vomiting	Yes	No
Diarrhea	Yes	No
Coughing	Yes	No
Sneezing/Discharge	Yes	No
Excessive Drinking	Yes	No
Excessive Urination	Yes	No

Describe your pet's appetite since the problem began: Not Eating ☐ Decreased ☐ Normal ☐ Increased ☐

Is your pet currently on any medications? Yes No
If so, please list:
____
____

Where does you pet spend his/her time? INDOORS OUTDOORS INDOOR/OUTDOOR

What does your pet normally eat?____

Is your pet current on vaccinations? Yes No

Do you give WVHMS permission to perform the following if indicated?

Labwork such as bloodwork or X-rays*	Yes	No
Sedation or general anesthesia	Yes	No
CPR	Yes	No

*please note that orthopedic radiographs often require sedation for adequate positioning, consent for both will facilitate timely treatment.

☐ Please treat my pet without calling me, I authorize up to $_________________ to be spent without a treatment plan being prepared. I understand payment is expected at the time I pick up my pet.

☐ Please call me with a treatment plan with associated costs prior to performing tests or treatments

Preferred method of communication: Call ☐ Txt ☐

Phone Number_____________________________ Secondary Phone Number____________________________

______________________________ Signature

______________________________ Date

Checked in by: _______________________________________