Curbside Drop Off Exam Form

Name: _____ **Date of Birth:** _____

Spayed/Neutered: Y/N (circle one)

Drop Off Time: _____

Contact Person: _____ **Phone Number Today:**_____

Reason for Visit: _____

_____

Patient History:

- **Coughing/Sneezing? Yes / No (circle one)**
  - If so, how long?_____
  - When did signs first occur? _____
  - How frequent is this occurring? _____
- **Vomiting? Yes / No (circle one)**
  - If so, how long?_____
  - When did signs first occur? _____
  - How frequent is this occurring? _____
- **Diarrhea or Soft Stool? Yes / No (circle one)**
  - If so, how long?_____
  - When did signs first occur? _____
  - How frequent is this occurring? _____

Travel History:

- **Cats – indoor only? Yes / No (circle one)**
- **Dogs – where has your pet gone (in state/out of state in the past 5 years (if applicable)?**

  _____

Have you noticed any changes in your pets:

- **Appetite? Yes / No (circle one)**
  - If so, has it increased or decreased?_____ When did this start? _____
- **Water Consumption? Yes / No (circle one)**
  - If so, has it increased or decreased?_____ When did this start? _____
- **Activity Level? Yes / No (circle one)**
  - If so, has it increased or decreased?_____ When did this start? _____
- **Behaviors? Yes / No (circle one) – Hiding/Ignoring training, licking?**
  - What are they doing that they haven't done before _____
  - When did this start? _____
- **Any other concerns today? Yes / No (circle one)**
  - _____
- **Have you tried anything for anything above listed at home? Yes/No (circle one)**
  - _____

MEDICATIONS:

This includes prescribed medications, over-the-counter medications, dietary supplements, flea/parasite treatments or preventatives.

_____

_____

_____

Diet:

What kind of food does your pet eat? Brand: _____

- Wet / Dry / Both? Yes / No (circle one)

How much per day? _____

After the doctor has done their exam we will contact you with an estimate either car-side or via phone at the number above.