DROP-OFF EXAM QUESTIONNAIRE

Last Name: _____ Pet's Name: _____ Date: _____

1) Please check all problems that apply to your pet.

- o Coughing
- o Sneezing
- o Itchy Skin
- o Lethargic
- o Losing Weight
- o Vomiting _____ times a day
- o Limping- right__ left__ front__ rear__
- o Difficulty defecating
- o Eye Discharge
- o Nose Discharge
- o Shaking Head
- o Scratching at Ears
- o Having Seizures _____times per – Day / Week / Month
- o Other_____

2) How long has your pet displayed these problems? _____

3) Check all the boxes that best describe your pet's appetite and drinking habits.

- o No change in water intake
- o Drinking more
- o Drinking less
- o Not drinking at all
- o Seems thirsty, but reluctant to drink
- o No change in appetite
- o Eating more
- o Eating less
- o Not eating at all
- o Seems hungry, but reluctant to eat

4) Check the boxes that best describe your pet's urine output and bowel movements.

- o No change in urine output
- o Increased urine output
- o Decreased urine output
- o Formed stool
- o Semi-formed stool
- o Watery stool

5) What are you currently feeding your pet?

- o Dry Food which brand? _____
- o Canned Food which brand? _____
- o People Food

6) Have you recently changed your pet's diet? Yes No

If yes, what were you previously feeding? _____

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

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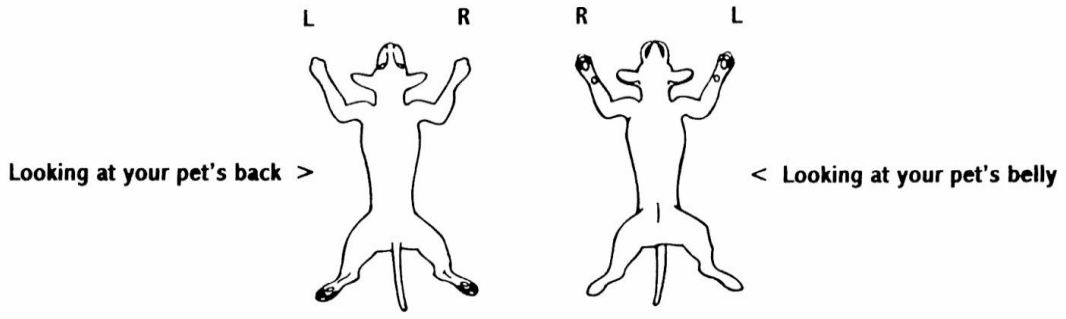

8) Where does your pet spend his/her time?
- o Only indoor (never outside)
- o Mainly indoor
- o Mainly outdoor
- o Equal time indoor/outdoor

9) If your pet's vaccines are not up to date, do you want them brought up to date today if the doctor feels your animal is healthy enough? Yes No

10) Is your pet currently receiving a monthly flea, intestinal parasite and heartworm preventative? (Examples—Sentinel, Advantage, Heartgard) Yes No

11) Is your pet receiving any other medications? Please list all medications and the daily doses you are administering._____
_____
_____

12) Does your pet have any allergies to medications? Yes No Please list:_____
_____
_____

13) In order to quickly and efficiently diagnose your pet's condition, your pet may require blood tests, x-rays, and/or other diagnostic testing. Do you authorize us to perform these tests if the doctor feels it is warranted? Please initial below.

_____ Yes, proceed with any doctor recommended diagnostic testing.
_____ Please contact me prior to performing any diagnostic testing.

14) It is very important that the doctor is able to contact you if there are questions regarding your pet. Please leave the following phone numbers and the time you can be reached at each number.
Home Phone _____Times_____
WorkPhone_____Times_____
Cell Phone _____Times_____

15) Please list any other comments or questions you would like to be relayed to the doctor.
_____
_____
_____
_____

Thank you for helping us better serve you. Your pet will be examined as soon as possible, in between scheduled appointments and/or surgery. (Any critical patients will be examined immediately) Pick up times cannot be guaranteed, but we will do everything we can to accommodate your schedule.

Preferred Pick-Up Time: _____ AM / PM