



DROP-OFF EXAMINATION FORM

Owner Name _____ Pet Name _____

Reason for Visit:

When did you first notice the problem? _____

Has your pet had any loose stool? Yes No

If yes, please describe _____

Has your pet had any vomiting? Yes No

If yes, please describe. _____

Is your pet eating and drinking? Yes No

Has this situation/problem occurred before? Yes No

Is your pet current on vaccinations? Yes No

If no, would you like for us to give vaccinations? Yes No

Is your pet on heartworm prevention? Yes No

If no, would you like for us to test for heartworms? Yes No

Is your pet on any medications? Please List. _____

Has your pet ever had a reaction to medications or vaccinations? Yes No

Please list anything else that you feel may be of importance to the diagnosis or treatment of your pet:

A staff member will call you after the exam, please provide a phone number where you can be reached today.

Phone # 1 _____

Phone # 2 _____

**Pets cannot be picked
up between 12 - 2 PM**

I hereby authorize Animal Medical Center to perform diagnostic and therapeutic procedures necessary for the maintenance and well being of my pet's health. I understand that I assume financial responsibility for all services rendered and that payment is due at the time of discharge.

Owner Signature _____ Date _____