rankin animal clinic
drop off form

Owner's Name _____Pet's Name _____ Date _____

Please check the significant problems that apply to your pet and prioritize by number

- o Coughing
- o Itching
- o Lethargic
- o Losing weight
- o Vomiting ____ times/day
- o Diarrhea
- o Limping: front rear right left
- o Difficulty urinating
- o Difficulty defecating
- o Eye discharge
- o Nose discharge
- o Sneezing
- o Shaking head
- o Scratching ear(s): right left
- o Having seizures ____ times per d/w/m
- o Other _____

How long has your pet displayed these problems?

_____
_____

Describe your pet's appetite and drinking habits

_____
_____

Describe your pet's urine and bowel habits

_____
_____

What are you currently feeding your pet?

Dry food, which brand? _____
Canned food, which brand? _____
People food _____
Is this a recent change? Y / N
If yes, what were you previously feeding?_____
_____

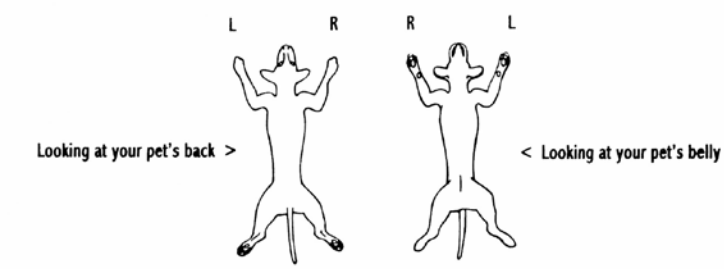
Where does your pet spend his/her time?

- o Only indoor (never outside)
- o Mainly indoor
- o Mainly outdoor
- o Leash walk neighborhood or visit dog park

Brand Heartworm preventative:_____
Date of last dose:_____
Brand Flea preventative:_____
Date of last dose:_____

Is your pet currently receiving any other medications? Please list medications and daily doses:_____
_____
_____

If your pet has lumps, bumps, cuts, sores that you wish us look at please note the area on the diagram below



In order to diagnose your pet's condition, your pet may require lab tests, x-rays, and/or other diagnostic testing. Do you authorize tests if the doctor feels it is warranted? Please initial below:
_____ Yes, proceed with any doctor recommended diagnostic testing.
_____ No, contact me prior to performing any diagnostic testing.
It is very important that we are able to contact you if we have questions regarding your pet. Failure to be reached may result in postponement of treatment.
Number you can be reached today _____
Alternate contact _____

Please list any other comments or questions you have for the doctor

_____
_____
_____
_____

Please indicate any other services you would like today:

- o Update vaccinations
- o Microchip
- o Trim nails
- o Bathe (includes nails, ears and anal glands)
- o Refill medications _____
  _____
- o Other_____

Preferred pick up time:_____