



Drop Off Form

Skin

Itching? Yes /No If yes, where? _____

Hair loss? Yes /No If yes, where? _____

Any problems with Fleas? Yes /No Or **Ticks?** Yes /No

Any changes at home? Yes /No If yes, explain _____

Duration? _____

Other pets itching/hair loss? Yes /No Or

Any family members itching? Yes /No If yes, explain _____

Check growth? Yes /No If yes, where? _____

Any changes (growing, getting hard, and etc)? _____

Duration? _____

Eyes

Which eye? Right /Left /Both Squinting? Yes /No

Discharge? Yes /No If yes, what color? _____

Duration? _____

Ears

Which ear? Right /Left /Both Shaking head? Yes /No

Scratching? Yes /No Odor? Yes /No Discharge? Yes /No

Duration? _____

Vomiting/Diarrhea

Vomiting? Yes /No Frequency (per day)? _____ Duration? _____

Vomiting Food? Yes /No Or Vomiting Water? Yes /No

Does the vomit contain blood? Yes /No If yes, how much? _____

Diarrhea? Yes /No Frequency (per day)? _____ Duration? _____

Does the diarrhea contain blood? Yes /No If yes, how much? _____

Diet change? Yes /No If yes, explain: _____

Eating foreign objects (grass, trash, table scraps, toys and etc.)? _____

Urination

Urinating in strange places? Yes /No Straining? Yes /No

Does the urine contain blood? Yes /No Painful? Yes /No

Frequency (per day)? _____ Duration? _____

Diabetic

What type of Insulin? _____ How much? _____

How often? _____ When was the last dose given? _____

Eaten this morning? Yes /No If yes, how much? _____

General Information

Any additional information? _____

Any known reaction to a medication or vaccination? _____

Current medications and the last time they were given (including Heartworm Prevention)? _____

Any pre-existing problems Acre View is not aware of? _____

Do you authorize any blood work Yes /No , radiographs Yes /No , or

additional diagnostics Yes /No ? **Please initial** _____

What is the best contact number today? _____ Is there an alternative number? _____