HENDERSON COUNTY VETERINARY HOSPITAL
DROP OFF ADMITTANCE

Thank you for giving us an opportunity to care for you pet. To ensure the best care possible, please take time to fill this form out completely as possible.

Client Name: _____ Pet Name: _____

Pet being dropped off for what problem: _____
How long have the symptoms been present? _____
Has the problem been worsening / improving / staying the same? _____
Are these symptoms new or recurring? _____
Are any other pets or family members exhibiting similar signs? _____
Please check any of the following symptoms if observed:

☐ Vomiting	☐ Diarrhea	☐ straining to defecate	☐ Appetite Loss	☐ Blood in stool
☐ Straining to urinate	☐ Difficulty eating	☐ Mucus in stool	☐ Increased urination	☐ Loss of energy
☐ Vision loss	☐ Increased water Consumption	☐ Panting	☐ Coughing	☐ Sleeps more
☐ Gagging	☐ Weight gain	☐ Weight loss	☐ Weakness	☐ Limping
☐ Difficulty rising/stiff	☐ Itching	☐ Licking	☐ Shaking head	☐ Hair loss
☐ Odor	☐ Lump or masses	☐ Behavior	☐ Seizures	☐ Collapse

Vaccination Status: Current or Needs the following: _____
Known Drug Allergies / Reactions: _____
Please list your pet's diet: _____ Have you changed your pet's diet? Yes No If yes, from what to what? _____
Flea control? Yes No If Yes, what? _____ Heartworm preventative? Yes No If yes, what? _____

Current Medication	Current Dosage	Last Date/Time Given

(Please list additional medications on the back: Additional medications: Yes No)

Is your pet inside or outside? _____
Has the routine changed at home in any way? _____
If there is any other information that could help us, please provide it below: _____
_____

I hereby authorize Doctor or Doctor's agents to perform the following on my pet, after examination before calling for confirmation _____ ***and / or to spend up to the following amount (in addition to the exam fee) before contacting me: up to $200 or $_____.***

The Doctor will call you as soon as possible to provide you with a treatment plan and an estimate for proposed services. **In the event that we have trouble contacting you, please be sure to call us if you don't hear from us by noon.**

Printed Name (person completing form): _____
Signature: _____
Contact #: _____
Additional Contact: _____ Contact #: _____

(Additional information on back)

Additional information:

Current Medication	Current Dosage	Last Date/Time Given