CAPITAL HEIGHTS VETERINARY CLINIC

PET DROP OFF INFORMATION

Client Name: _____

Telephone Number to reach you today: _____

If your pet is boarding, would you like a phone call after the exam? YES/NO

Pet's Name: _____

When was your pet's last meal? _____ What did he/she eat? _____ Any vomiting? _____

What medications (if any) has your pet received in the last 24 hours?

Name of medication	Amount given	What time

Is your pet sensitive or allergic to any medications or food? Yes [ ] No [ ]
(if yes please list) _____

Please describe the problem(s) your pet is having, pertinent history leading up to the current condition and any previous major medical problems._____

_____

If deemed necessary, do we have your permission to perform:

labwork [ ] xrays [ ] call first [ ]

In admitting my pet(s) for diagnostics and treatment, I authorize the veterinarian of Capital Heights Veterinary Clinic, and their support staff, to administer such treatment and/or perform such diagnostic(s) as deemed necessary.

Owner signature: _____ Date: _____