Puyallup Valley Veterinary Hospital Drop Off Form

Client Name:_____ Phone Number:_____

Emergency Contact Name:_____ Emergency Contact Number:_____

Please circle Are You: Owner/Spouse/Partner/Son/Daughter/Friend/Other:_____

Please check all that apply

___	Straining to Urinate	___	Watery Eyes	___	Constipation	___	Hair Loss
___	Vomiting	___	Shaking Head	___	Decreased Water Intake	___	Weakness
___	Diarrhea	___	Lethargic	___	Increased Water Intake	___	Gagging
___	Weight Loss	___	Depressed	___	Increased Appetite	___	Scooting
___	Weight Gain	___	Difficulty Breathing	___	Decreased Appetite	___	Scratching
___	Frequent Urination	___	Restlessness	___	Coughing	___	Odor
___	Seizures	___	Panting	___	Limping		

Change in Behavior? **Yes/No** How? _____

Discharge? **Yes/No** Where?_____

Pain? **Yes/No** Where?_____

Please describe in further detail any symptoms marked above including location:_____

_____

_____

_____

How long has your pet had these symptoms:_____

Is your pet on any medications or dietary supplements? **Yes/No** If so, please list medication and why:_____

_____

What type, brand and approximate amount of food are you currently feeding?_____

Canned:_____

Dry:_____

People Food:_____

Treats: _____

What has the pet eaten in the last 12 hours:_____

_____

Please Choose One:

❑ *Please call me after the exam and before any other treatments are performed*
(please check only if you are available to be reached by phone)

❑ *I authorize PVVC to perform the following before notifying me: (Please check the ones that apply below)*

___	Physical Exam	___	Bloodwork	___	Urinalysis	___	Update Vaccines
___	Fecal Analysis	___	Radiographs	___	Sedation/Anesthesia	___	Flea treatment

Other Treatments:_____

Authorized Signature:_____ Date:_____

Printed Name:_____