CHELSEA ANIMAL HOSPITAL

Drop Off Check In Sheet

Pet's Name: _____ **Owner:** _____

What is the main reason for your pet's visit today? Please provide detail.

_____

_____

_____

How long has this problem been going on? _____

Is the problem better or worse? _____

Does your pet have any of the following symptoms? Please check box.

___ Lack of Appetite ___ Scratching ___Weight: gain/loss

___Diarrhea ___Seizures ___Blood in Stool

___Abnormal Urination ___Vomiting ___Abnormal drinking

___Limping ___Coughing/Sneezing ___Other _____

Is your pet on Heartworm or Flea/Tick preventative?_____

Is your pet currently on and medications? _____

Has your pet ever had any reaction to medications/vaccines? _____

Does your pet have any past problems that may not be in our records? If so, what is the medical issue? _____

If the veterinarian thinks it is necessary, do we have permission to do: (check box to agree that we may perform procedures) ___ Blood Work ___X-Rays

Please leave the best telephone numbers to reach you: _____

Signature:_____ Date: _____