



MERRIFIELD ANIMAL HOSPITAL DROP OFF FORM

Staff Initials: _____

Patient: _____

Owner: _____

Why are we seeing your pet today?

- Wellness Exam
 Sick pet exam
 Boarding with exam

If physical problems are noted during the exam, do we have permission to start treatment?

- Yes
 No

Diet:

- Dry
 Wet/canned

Brand: _____

Amount: _____

Time of last meal: _____

Medications (select all that apply):

- Flea & Tick – Brand: _____ Date last given: _____
 Heartworm preventative – Brand: _____ Date last given: _____
 Other: _____

Does your pet have any of the following symptoms (select all that apply):

- Vomiting
 Diarrhea
 Constipation
 Coughing
 Sneezing
 Nasal discharge
 Eye discharge
 Itchy skin/ scratching
 Limping/lameness
 Change in appetite (circle): Increased – Decreased
 Change in water consumption (circle): Increased – Decreased
 Urinary issues (circle): Increased – Decreased – Straining
 Change in behavior
 Other

Please elaborate on any symptoms checked above (start date, frequency, etc):

Signature: _____

Date: _____