



OWNER _____

PATIENT _____

SAMPLE DROP OFF PATIENT HISTORY

DATE _____

1) **What are the symptoms? (What SPECIFICALLY is the animal doing?) Please describe in detail what you are seeing your pet doing:**

2) How long have you noticed the symptoms?

3) Have these symptoms occurred before? When?

4) What is the frequency of the occurrence and was the problem previously diagnosed?

5) Is your animal eating and drinking normally? _____

6) Is your animal having any vomiting or diarrhea? _____

7) Is your animal urinating and defecation normally? _____

8) Is your animal's energy level normal? _____

9) If your animal is a **cat**, is s/he indoor, outdoor, or both? (please circle one)

10) What is the normal diet of your animal? (Brand, type, amount, frequency)

11) Is your animal currently on any medications? When was their last dose given?

12) Is your pet current on vaccines? Yes / No Date last given: _____

Best number to reach you by for Results: _____

OFFICE USE ONLY: LIST DATE AND TIME

RESULTS INTERPERATED: _____ OWNER CALLED: _____ TECH INITIALS: _____