Animal Medical Center Copperas Cove

Date: _____ Drop Off History Form Tech_____ Receptionist_____

Client Name: _____ **Patient Name:** _____

Contact number(s):_____

Reason for your visit today: _____

_____

_____

Do you authorize labwork? Yes / No
Do you authorize X-rays? Yes / No

Please indicate your pet's level of discomfort today:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

How long have you noticed these symptoms? _____ **Frequency?** _____
Are these symptoms improving, getting worse, or the same? _____

Have you noticed any of the following symptoms: (please CIRCLE the symptom(s) then describe further if needed)

Vomiting / Retching _____
Diarrhea _____
Coughing / Sneezing / Nasal Discharge _____
Difficulty Breathing _____
Stiffness / Limping /Lameness _____
Right front, left front, right rear, left rear
Shaking / Wobbly _____
Shaking Head _____
Change in attitude or behavior _____
Skin / Hair / Coat Changes _____
Excessive Licking / Chewing / Itching _____
Other _____
Growths or Lumps (Use Chart Below) _____

Ventral Dorsal (Bottom) (Top)

Appetite:	Increased	Decreased	No change
Water consumption:	Increased	Decreased	No change
Activity Level:	Increased	Decreased	No change
Urine	Increased	Decreased	No change

What medications or supplements do you give your pet? _____

Has your pet been given any medications today? Yes / No **If so, which one(s) and at what time?**

_____

Has your pet been fed today? **Yes/No** **What type of food do you feed your pet?** _____

Is your pet allergic to any medications? _____

Do you need any medication refills? _____