

DATE:

**BUCKHEAD ANIMAL CLINIC PET DROP-OFF FORM**

OWNER'S NAME: \_\_\_\_\_

PET'S NAME: \_\_\_\_\_

WHAT NUMBER/S CAN WE REACH YOU AT TODAY? \_\_\_\_\_  
\_\_\_\_\_

PLEASE CIRCLE THE PRIMARY PROBLEM/S OR REASON FOR YOUR VISIT:

- |                                 |   |
|---------------------------------|---|
| 1. VOMITING                     | 4. COUGHING OR SNEEZING                   |
| 2. DIARRHEA                     | 6. LAMENESS                               |
| 2. SCRATCHING OR ITCHING        | 7. POST SURGERY OR OFFICE VISIT FOLLOW UP |
| 3. CHANGE IN ELIMINATION HABITS | 8. OTHER (PLEASE EXPLAIN BELOW)           |

PLEASE DESCRIBE YOUR PET'S CURRENT SYMPTOMS AND/OR BEHAVIORS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DURATION OF THE PROBLEM/S: \_\_\_\_\_

IF RECURRENT, WAS OUR PREVIOUS TREATMENT EFFECTIVE? \_\_\_\_\_

HAS THERE BEEN ANY CHANGE IN YOUR PET'S APPETITE?      YES      NO

IF YES, HOW HAS IT CHANGED? \_\_\_\_\_

WHAT TYPE OF FOOD HAS YOUR PET BEEN EATING? \_\_\_\_\_

IS YOUR PET CURRENTLY ON ANY MEDICATIONS? IF SO, PLEASE LIST EACH MEDICATION AND INDICATE

WHEN EACH WAS LAST GIVEN: \_\_\_\_\_  
\_\_\_\_\_

IS THERE ANY OTHER INFORMATION WE SHOULD KNOW?

\_\_\_\_\_  
\_\_\_\_\_

IS YOUR DOG ON HEARTWORM PREVENTION?      YES      NO

DO YOU NEED TO PICK UP ANY PRESCRIPTION REFILLS OR FOOD WHEN YOU RETURN?

\_\_\_\_\_  
**I AUTHORIZE THE BUCKHEAD ANIMAL CLINIC TEAM TO EXAMINE AND TREAT MY PET/S.**  
SIGNATURE OF OWNER/AGENT: \_\_\_\_\_