



DOCTORS PET CLINIC

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Medical Drop-Off Form Please Fill Out Completely

For drop off patients with medical problems please choose your preference:

- () Please call after the exam and prior to initiating diagnostics or treatment with an estimate.
() Please examine and treat my pet as needed and call when finished.

Is your pet experiencing any of the following problems?:

| | | | |
|------------------------|---------|--------|----------------|
| Vomiting? | Yes ___ | No ___ | Comments _____ |
| Diarrhea? | Yes ___ | No ___ | Comments _____ |
| Straining to urinate? | Yes ___ | No ___ | Comments _____ |
| Straining to defecate? | Yes ___ | No ___ | Comments _____ |
| Increased thirst? | Yes ___ | No ___ | Comments _____ |
| Decreased thirst? | Yes ___ | No ___ | Comments _____ |
| Increased appetite? | Yes ___ | No ___ | Comments _____ |
| Decreased appetite? | Yes ___ | No ___ | Comments _____ |
| Lumps? | Yes ___ | No ___ | Comments _____ |

Please describe any other problems you have noticed in your pet: _____

Has your pet been vaccinated within the last year and where? _____

Is your pet indoor only, outdoor only or indoor/outdoor? (Circle one)

When did your pet last eat? _____

What did your pet last eat? _____

What is the brand of your pet's diet? _____

Please list your pets' medication given, the time it was given, and the dose that was given: _____

Please call later in the day to obtain follow up information on your pet's condition. Do not leave any collars, leashes, carriers, toys, etc., as these items can easily be misplaced. Animals entering the hospital with fleas will be treated at the expense of the owner. Please be advised that pet supervision is between 7am - 6pm. _____ (Please Initial)

Phone number (s) where you can be contacted readily:

() _____ between the hours of _____

() _____ between the hours of _____

Owners Name _____ Pets Name _____

Signature _____ Date _____