Brea Veterinary Hospital
Drop Off Form

Owner: ____ **Date:** _____________
Pet's Name: _______________________________________
Reason for Exam: ______________________________ **Duration of Problem**__________

Please Check the Following:
Activity Level: **Normal** ____ **Decreased** _____ **Increased** _____
Appetite: **Normal** ____ **Decreased** _____ **Increased** _____
Water Intake: **Normal** ____ **Decreased** _____ **Increased** _____

Urination: **Normal** ____ **Decreased** _____ **Increased** _____
Any blood or straining during urination? _____________
Any leakage detected? ________ **Any Accidents?**________

Bowel Movement: **Normal** _____ **Decreased** _____ **Increased** _____
Diarrhea? ______ **If Yes, any blood or mucus?** _____
Worms Seen? ______ **Describe** ____________________

Coughing? **No** ____ **Yes** ____ **How Long** _____________________________
Describe_______________________________
Sneezing? **No** ____ **Yes** ____ **How Long** _____________________________
Describe_______________________________
Vomiting? **No** ____ **Yes** ____ **How Long** _____________________________
Describe_______________________________
Itching? **No** ____ **Yes** ____ **If Yes, where?**_________________________

We take every precaution to provide a **flea free** environment. Any animal showing a flea infestation as determined by staff at check in **WILL BE REQUIRED to** receive a dose of flea control upon admission, and the ***owner will be financially responsible.***

Discharge Present? Eyes ____ **Ears** ____ **Nose** ____ **Vagina** ____ **Penis** _____
Describe Discharge ____

What do you feed your pet? ____

Current Medications **(Please indicate your pet's current dose):** __________________
____

IF YOUR DOG IS NOT SPAYED, GIVE DATE OF LAST HEAT CYCLE _______

CATS: INDOOR ONLY ______ **BOTH INDOOR AND OUT** _______

I authorize treatment as deemed necessary by the veterinarian. Yes ___ **No** ___
IF NO, Please call me if the diagnostics and /or treatment fees will exceed $_________
Please call me at (   ) _______________ **after examination with results, treatment plan estimate.**

Owner/Responsible Party _______________________