

## Client Drop-off History Report

Client ID: \_\_\_\_\_

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Vomiting/Diarrhea History (Subjective):					
Yes	No	Vomiting	Yes	No	Diarrhea
		How often is your pet vomiting?			How often is your pet having diarrhea?
<input type="checkbox"/>	<input type="checkbox"/>	Are there large volumes of vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	Is there blood in the stool?
<input type="checkbox"/>	<input type="checkbox"/>	Are there pieces of whole food in the vomit?	<input type="checkbox"/>	<input type="checkbox"/>	Is there mucus in the stool?
<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	Current on vaccinations (ex. Leptospirosis)?
<input type="checkbox"/>	<input type="checkbox"/>	Any missing toys?	<input type="checkbox"/>	<input type="checkbox"/>	Any recurrent minor illnesses?
<input type="checkbox"/>	<input type="checkbox"/>	Noticed any blood in vomit?	<input type="checkbox"/>	<input type="checkbox"/>	Recent injuries, abscesses, cat fights, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Eating Changes? <input type="checkbox"/> Increased <input type="checkbox"/> Decreased	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight, muscle atrophy, fatigue, weakness?
Additional notes:					

Orthopedic History (Subjective):	
Is your pet painful? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, add pain score: _____	When was the problem first noted? _____
Does your pet have difficulty with the following? Check all that apply <input type="checkbox"/> walking <input type="checkbox"/> running <input type="checkbox"/> climbing <input type="checkbox"/> jumping <input type="checkbox"/> other _____	
Any known injury, previous trauma or surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Which leg(s) are affected? <input type="checkbox"/> RF <input type="checkbox"/> LF <input type="checkbox"/> RR <input type="checkbox"/> LR
How often does your pet exercise regularly? _____	Is your pet on any medications, vitamins or supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Notes:	

Urinary History (Subjective):					
Yes	No	Vomiting	Yes	No	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Normal mental Status?	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any chemicals?
<input type="checkbox"/>	<input type="checkbox"/>	Changes in drinking patterns?	<input type="checkbox"/>	<input type="checkbox"/>	Current on vaccinations including Leptospirosis?
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination? How long has this been going on? _____ days	<input type="checkbox"/>	<input type="checkbox"/>	Any recurrent minor illnesses?
		How much water does your pet drink daily?			
<input type="checkbox"/>	<input type="checkbox"/>	Any past history of urinary problems?	<input type="checkbox"/>	<input type="checkbox"/>	Recent injuries, abscesses, cat fights, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Any wet spots where pet has been laying?	<input type="checkbox"/>	<input type="checkbox"/>	Cachexia?
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting or Diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Minor Illnesses
<input type="checkbox"/>	<input type="checkbox"/>	Any blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating? <input type="checkbox"/> Increased <input type="checkbox"/> Decreased
Additional notes:					

Dermatology History (Subjective):	
Does your pet itch/lick/chew/bite itself? Yes <input type="checkbox"/> No <input type="checkbox"/>	When was the problem first noted? _____
Where does your pet itch? Check all that apply. <input type="checkbox"/> Face <input type="checkbox"/> Ears <input type="checkbox"/> Under arms <input type="checkbox"/> Abdomen <input type="checkbox"/> Front Feet/Legs <input type="checkbox"/> <input type="checkbox"/> Back feet/Leg <input type="checkbox"/> Lower back <input type="checkbox"/> All over	How bad is the itching? Scale 1 to 10 <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Constant <input type="checkbox"/> Periodic
Where did the problem begin? _____	Is the problem seasonal? _____
Does your pet have hairloss? Yes <input type="checkbox"/> No <input type="checkbox"/>	What do you feed your pet? _____
Outdoor pet? Yes <input type="checkbox"/> No <input type="checkbox"/> Any other Pets in the house? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Additional Notes:	

Ophthalmology History (Subjective):					
Yes	No	Vomiting	Yes	No	Diarrhea
		What eye is affected? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both			
<input type="checkbox"/>	<input type="checkbox"/>	Is your pet squinting?	<input type="checkbox"/>	<input type="checkbox"/>	Outdoor pet? Any other pets in the house?
<input type="checkbox"/>	<input type="checkbox"/>	Is there any discharge from the eye(s)?	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting/Diarrhea?
<input type="checkbox"/>	<input type="checkbox"/>	How long has this been going on?	<input type="checkbox"/>	<input type="checkbox"/>	Any recent illness?
<input type="checkbox"/>	<input type="checkbox"/>	Any past issues with the eyes?	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to any chemicals (including shampoo)?
<input type="checkbox"/>	<input type="checkbox"/>	Eating Changes? <input type="checkbox"/> Increased <input type="checkbox"/> Decreased	Additional Notes:		