

# Drop-Off Information

Our best source of information about your pet is you. Please fill this form out accurately and completely to enhance our ability to help your pet.

Owner's Name:	Pet's Name:
At what telephone number can you be reached today?	
If you can only be reached at a specific time, please indicate the best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM	
1. What is the main reason for bringing your pet in today?	
<i>How long has this problem been going on?</i>	
2. Has your pet recently or currently been on any medication? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, what?</i>	
3. Please describe your pet's current diet:	
4. Your pet's appetite is: <input type="checkbox"/> Normal <input type="checkbox"/> Always Hungry <input type="checkbox"/> Poor <input type="checkbox"/> Not Eating <i>If abnormal, for how many days?</i>	
5. Your pet's water consumption is: <input type="checkbox"/> Normal <input type="checkbox"/> Excessive <input type="checkbox"/> Poor <input type="checkbox"/> Not drinking	
6. Your pet's bowel movement is: <input type="checkbox"/> Normal <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other	
<i>If diarrhea, give frequency and duration:</i> _____ times per day for _____ Days or _____ Weeks	
7. Your pet's urination is: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <i>If abnormal, describe:</i>	
8. Is your pet vomiting? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, give frequency and duration:</i> _____ times per day for _____ Days or _____ Weeks	
9. Is your pet sneezing or coughing? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<i>If yes, give frequency and duration:</i> _____ times per day for _____ Days or _____ Weeks	
10. Is your pet limping? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, which leg is affected?</i> _____ Duration of limping: _____ Days	
<i>Describe your pet's limp:</i> <input type="checkbox"/> All of the time <input type="checkbox"/> Only after getting up <input type="checkbox"/> Only when walking <input type="checkbox"/> Only when running	
11. Have you noticed a weight change? <input type="checkbox"/> No <input type="checkbox"/> Yes, weight gain <input type="checkbox"/> Yes, weight loss	
12. Has there been a change in your pet's activity? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, describe:</i>	
13. Please describe any other changes in your pet that you have noticed:	

All patients must be current on vaccinations or they will be given at admittance unless your pet is too ill to receive them.

Do we have your permission to proceed with additional tests or treatment related to your pet's current condition (up to \$50 beyond the physical exam) prior to contacting you?

Yes  No

At what time today (during office hours) will you pick up your pet?  AM  PM



**Jordan Creek Animal Hospital**  
3401 E.P. True Parkway  
West Des Moines, IA 50265  
(515) 224-9500