MillsVet

Drop Off or New Patient Form

Owner's Name (first and last): _____ **Date:** _____

Address: _____

Phone Number(s): _____

Email Address: _____

Secondary owner name: _____

Secondary owner phone number: _____

Pet's Name _____

Age/DOB: _____

Species (dog or cat)

Sex (male, female, neutered male, spayed female)

Color: _____

Is your pet microchipped? Yes_____ No_____ Microchip #:_____

Does your pet suffer from severe anxiety or fear aggression? _____

_____

Reason for visit: _____

_____

_____

_____

Current medications or supplements and when they were last given:

_____

Does your pet have any allergies: _____

Current diet: _____

Any vomiting? Yes ___ No___ Unsure___

If so, when did it start and how often since? _____

Any diarrhea or bowl movement concerns? Yes____ No____ Unsure ____

If so, when did it start and how often since? _____

Is your pet still eating normally? Yes___ No____ Increased____ Decreased___

When did they last eat? _____

How are their water drinking habits? Normal___ Increased _____Decreased____

Explain if changed/concerns_____

Any changes in urination? No__ Yes___ (Increased ___ or Decreased___)

If yes, are they having accidents in the house or just an increase in frequency? Is it when they are awake or resting or asleep? Please explain.

_____

_____

_____

Are there any lumps, bumps, or injuries that you are concerned about?

_____

_____

_____

Any previous adverse effects to medications or anything else about your pet that we should know about?

_____

Any mobility problems? **Limping** or slow/painful movements? Yes ____ No___

If yes, please describe_____

Last time your pet was **dewormed**? ____ Would you like dewormer today? Yes ___ No ____

Are your pet's **vaccinations** current? Yes ____ No ____

Where were the vaccinations done (name of former clinic)? _____

If needed, would you like the vaccines updated today? Yes ____ No ____

Payment is required at the time of services