DROP-OFF AUTHORIZATION FORM

Owner's Name: _____

Pet's Name: _____

Cell Phone Number: _____

Alternative Phone Number: _____

Email Address: _____

Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email

AUTHORIZATION FOR MEDICAL CARE

I authorize Five Oaks Animal Hospital and its doctors to perform medical treatments and diagnostic tests that are deemed necessary to evaluate and ensure the health and well-being of my pet.

Owner's Initials: _____

I authorize Five Oaks Animal Hospital to provide examination and diagnostic services up to a maximum of $350 without obtaining additional authorization from me. I understand that this amount may not include medications or other treatments prescribed for my pet to go home.

Owner's Initials: _____

OWNER CERTIFICATION AND FINANCIAL RESPONSIBILITY

I certify that I am the owner or authorized agent of the owner of the animal described above. I hereby give Five Oaks Animal Hospital full and complete authority to examine and treat my pet as medically necessary within the authorization provided above.

I have read and understand this Drop-Off Authorization Form, including the hospital's policies and my financial responsibility for all services, treatments, medications, and diagnostic tests provided to my pet.

Owner's Signature: _____ Date:_____

FIVE OAKS ANIMAL HOSPITAL
PET MEDICAL HISTORY FORM
PET INFORMATION
Pet's Name: _____
Species: ☐ Dog ☐ Cat ☐ Other: _____
Breed: _____ Age: _____
Sex: ☐ Male ☐ Female ☐ Neutered ☐ Spayed ☐ Intact

REASON FOR TODAY'S VISIT
What is your primary concern or reason for bringing your pet in today?

_____

_____

When did you first notice the problem? _____
Has the problem:
☐ Improved ☐ Worsened ☐ Stayed the Same ☐ Comes and Goes

Please list all medications, preventatives, vitamins, supplements, or other products your pet is currently receiving.

Medication/Supplement	Dose	How Often	Last Given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES & PREVIOUS REACTIONS
Does your pet have any known allergies?
☐ No ☐ Yes
If yes, please list: _____
Has your pet ever had a reaction to a medication, vaccine, anesthesia, food, or other substance?
☐ No ☐ Yes
Please describe: _____

_____

PREVIOUS MEDICAL HISTORY

Has your pet ever been diagnosed with or treated for any of the following?

☐ Allergies
☐ Arthritis/Joint Problems
☐ Cancer/Tumors
☐ Diabetes
☐ Heart Disease
☐ Kidney Disease
☐ Liver Disease
☐ Seizures
☐ Thyroid Disease
☐ Urinary Problems
☐ Gastrointestinal Problems
☐ Skin Problems
☐ Respiratory Problems
☐ Other: _____

Please provide additional details or dates if applicable:

_____

_____

SURGERIES & HOSPITALIZATIONS

Has your pet ever had surgery or been hospitalized?

☐ No ☐ Yes

Please list the procedure, approximate date, and reason:

_____

_____

Has your pet ever had a problem with anesthesia?

☐ No ☐ Yes ☐ Unsure

Details: _____

VACCINATION & PREVENTATIVE CARE

Is your pet current on vaccinations?

☐ Yes ☐ No ☐ Unsure

Is your pet currently receiving flea/tick prevention?

☐ Yes ☐ No

Product: _____ Last Given: _____

Is your pet currently receiving heartworm prevention?

☐ Yes ☐ No ☐ Unsure

Product: _____ Last Given: _____

DIET & DAILY ROUTINE

What food does your pet eat?

Brand/Type: _____

Amount & Frequency: _____

Treats/Table Food: _____

Any recent change in diet? ☐ No ☐ Yes

If yes, please explain: _____

HOME & LIFESTYLE

Where does your pet primarily live?

☐ Indoors ☐ Outdoors ☐ Both

Other pets in the household? ☐ No ☐ Yes

If yes, please describe: _____

Does your pet have access to:

☐ Dog Park ☐ Boarding/Daycare ☐ Groomer ☐ Hunting/Farm Areas

☐ Other animals ☐ Unsupervised outdoor areas

CURRENT SYMPTOMS

Please check any symptoms you have noticed recently:

☐ Decreased Appetite

☐ Increased Appetite

☐ Increased Thirst

☐ Increased Urination

☐ Vomiting

☐ Diarrhea

☐ Constipation

☐ Coughing

☐ Sneezing

☐ Difficulty Breathing

☐ Limping

☐ Pain

☐ Lethargy/Low Energy

☐ Weight Loss

☐ Weight Gain

☐ Itching/Scratching

☐ Hair Loss

☐ Skin/Coat Changes

☐ Changes in Behavior

☐ Difficulty Urinating

☐ Blood in Urine/Stool/Vomit

☐ Other: _____

Anything else you would like the veterinarian to know?

_____

_____

_____

FOR OFFICE USE

Veterinarian: _____

Date: _____

Weight: _____ Temperature: _____

HR: _____ RR: _____

Additional Notes: