



**Companion Pet Clinic of NE 82<sup>nd</sup> Ave**  
*and*  
**Animal Wellness Center of Portland**  
 3345 NE 82<sup>nd</sup> Ave  
 Portland, OR 97220

**PATIENT DROP-OFF FORM**

**Owner's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Pet's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex: M / F ; N / S ?**

**Phone number(s) where you and/or person authorized to make decisions on your behalf may be reached *today*:**

*Name:* \_\_\_\_\_ *Ph#1:* \_\_\_\_\_ *Ph#2:* \_\_\_\_\_ *Ph#3:* \_\_\_\_\_

*Name:* \_\_\_\_\_ *Ph#1:* \_\_\_\_\_ *Ph#2:* \_\_\_\_\_ *Ph#3:* \_\_\_\_\_

**Please indicate all that apply to your pet's lifestyle:**

- indoor only    indoor/outdoor    outdoor only    only pet in home    multiple pets in home  
 regularly boarded/groomed    frequents dog parks    goes hiking    goes camping    swims

**Describe the current problem:** \_\_\_\_\_

**How long has your pet had symptoms?** \_\_\_\_\_

**Are the symptoms worse at certain times?** (e.g. after eating, when it rains, etc.) **YES / NO**

*If yes, please explain:* \_\_\_\_\_

**Has your pet had this problem before?** **YES / NO**      *If yes, when?* \_\_\_\_\_

**Has your pet been treated by a veterinarian for this problem?** **YES / NO**

*If yes, when and where?* \_\_\_\_\_

**Is your pet currently being treated for any other medical condition at this time?** **YES / NO**

*If yes, please explain and include the veterinary clinic where your pet was seen:* \_\_\_\_\_

**What does your pet's diet consist of? Please be as specific as possible, including daily amount fed:**

**Please list all medications and/or supplements your pet takes regularly, and how often each one is given.**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Has your pet missed any of his / her medication?** **YES / NO**

*If yes, please explain. Include what and when the last dose was.* \_\_\_\_\_

**Please list any *other* medications and/or supplements your pet has taken within the past 30 days.**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Has your pet ever had *any* type of reaction to any medications and/or vaccines?** **YES / NO**

*If yes, please explain:* \_\_\_\_\_

**Does your pet have a history of seizure(s)?** **YES / NO**

I understand that my pet will be thoroughly examined and evaluated by a veterinarian at Companion pet Clinic of NE 82<sup>nd</sup> Ave, and I will be responsible for the exam charges. The doctor and/or staff member will contact me or other authorized party with information on required treatment(s) and an estimate of related costs in addition to the aforementioned exam.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_