Little River Animal Hospital

Doctors Kraft, McFarland, Gholston

Date: ____/____/____

Owner:_____ Pet: _____

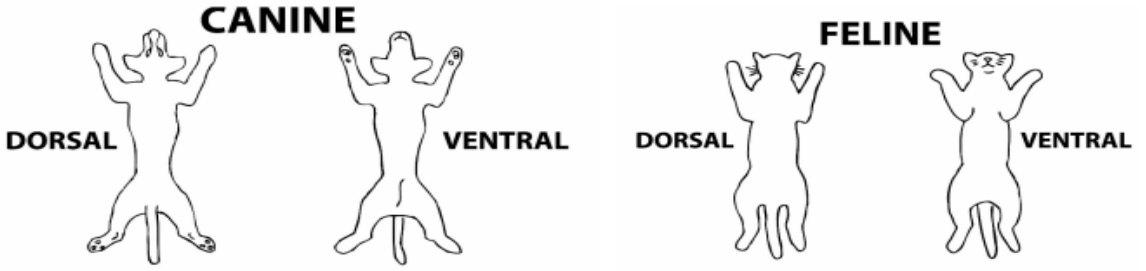
Phone Number: _____ Preferred Doctor _____

Reason for Drop Off Visit:_____

Due now or soon:_____

Please mark any current symptoms:

- ❑ Vomiting
- ❑ Lameness
- ❑ Skin Problems
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty Urinating
- ❑ Lack of Appetite
- ❑ Lethargic
- ❑ Coughing
- ❑ Sneezing
- ❑ Scratching
- ❑ Eye Problems
- ❑ Ear Problems
- ❑ No concerns
- ❑ Known allergies: _____



Additional concerns or questions:_____

Current medications/ last dose: _____

Please mark any non-medical service requests:

- ❑ Toe Nail Trim
- ❑ Toe Nail Dremeling
- ❑ Anal Gland Expression by Doctor
- ❑ Refill of medication or flea/tick/heartworm preventatives:_____

- ❑ I authorize whatever tests the doctor feels are necessary for the treatment of my pet
- ❑ I would like the doctor to call me before any tests or treatments are done beyond a physical exam

Signature:_____ **Date:**_____