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Country Veterinary Service

Curbside History Form

Owner's Name_____ Pet's Name: _____Best Contact # _____

What is your pet here for today? _____

Any known allergies? _____

Your pet's diet: Brand_____ Cup(s) per feeding ____ How many times daily _____

Any limping, pain stiffness or other mobility issues? _____

Current medications and/or supplements: _____

Is your pet on any preventatives? HEARTGARD PLUS / NEXGARD / FRONTLINE GOLD / REVOLUTION PLUS

Do you need refills? _____

Please check any changes that apply:

- ⇨ Appetite (increase/decrease)
  If so, explain_____
- ⇨ Thirst (increase/decrease)
  If so, explain_____
- ⇨ Defecation (normal/ soft/runny)
  If so, explain_____
- ⇨ Urination (increase/decrease/straining)
  If so, explain_____
- ⇨ Skin Issues (scratching/licking/chewing) (seasonal/year round)
  If so, explain_____
- ⇨ Ears (scratching/head shaking) (first time/chronic)
  If so, explain_____
- ⇨ Masses (location/ changes in size)
  If so, explain_____
- ⇨ Coughing (How long) (Worse with activity) (pattern to it)
  If so, explain_____
- ⇨ Sneezing (frequency/discharge present)
  If so, explain_____
- ⇨ Vomiting (When did it start/ dietary indiscretion)
- ⇨ Eyes (discharge/squinting/rubbing)
  If so, explain_____
- ⇨ Oral (smelly breath/ chewing on one side/ dropping food)
  If so, explain_____
- ⇨ Activity (lethargic)
  If so, explain_____

We advise geriatric bloodwork screening for all patients 6 years and older, if you do not want to pursue this, please check here ⇨.

Any other questions or concerns? _____

Authorization to treat your pet: _____ Date: _____

SUBMIT

This button only works in Acrobat. If you are having trouble, you can send the form in an email to: info@countryvetservice.com

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WELCOME

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Client Information

Name (Last Name First): _____ Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Driver License #: _____

Birthdate: _____ Employer: _____

Emergency Contact Name: _____ Emergency Contact Phone # _____

Primary reason for visit: _____

How did you learn about our practice?: _____

Pet Information

Pet's Name: _____ Dog____ Cat____ Other_____

Sex: ____ Male ____ Neutered ____ Female ____ Spayed At what age?: _____

Birthdate: _____ Breed: _____ Color_____

Previous Veterinarian/Clinic: _____ At what age was pet obtained?: _____

From: _____ Friend _____ Breeder _____ Pet Shop _____ Humane Society _____ Other_____

Reason for obtaining pet: ____ Companion ____ Protection ____ Breeding ____ Show ____ Other ____

Pet's Diet (brand, amount, frequency): _____

List your pet's current medications (include heartworm, flea and tick prevention):

_____

Please check any symptoms or problems you've noticed with your pet:

- ☐ Appetite Loss
- ☐ Behavioral Changes
- ☐ Breathing Problems
- ☐ Coughing
- ☐ Depression
- ☐ Diarrhea
- ☐ Eye Disorders:_____
- ☐ Gagging
- ☐ Gums Bleeding
- ☐ Limping
- ☐ Loss of Balance
- ☐ Scooting
- ☐ Scratching
- ☐ Shaking Head
- ☐ Sneezing
- ☐ Thirst
- ☐ Urination Increase
- ☐ Vomiting
- ☐ Weakness
- ☐ Other:_____
- ☐ Other:_____

Pet's History (check all that pet has received):

- ☐ Distemper
- ☐ Parvovirus (Dog)
- ☐ Rabies (Dog/Cat)
- ☐ Feline Leukemia Test
- ☐ FVRCP (Infectious Disease-Cat)
- ☐ Dental
- ☐ Prior Surgery:_____
- ☐ Prior Illness:_____
- ☐ Other:_____

Payment & Authorization

I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED. We will gladly prepare a written estimate for cost of services upon request (please ask technician or receptionist). I also understand that a deposit for surgery may be required at the time of drop off. We offer several options for payment including Cash, Checks, Care Credit, Visa, MasterCard, and Discover. We do not offer billing as an option. I have read, understand, and agree to the above terms.

Signature of client responsible for pet(s) _____ Date _____

FORM OF PAYMENT: CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ CARE CREDIT ☐

SUBMIT

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