

**Patient Drop-off Medical Form**  
**Roanoke Animal Hospital**

Owner's Name: \_\_\_\_\_ Patient's Name: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Primary Reason for Today's Visit: \_\_\_\_\_

Patient Diet: \_\_\_\_\_

Current Medications or Supplements: Y / N

If yes, please list type, dosage and frequency:

\_\_\_\_\_

Has the patient had any medications today? Y / N

If yes, please list type and time it was given: \_\_\_\_\_

\_\_\_\_\_

Is the patient on heartworm preventative? Y / N If Yes, what type? \_\_\_\_\_

Is the patient on flea/ tick preventative? Y / N If Yes, what type? \_\_\_\_\_

**Recent Medical History**

(please circle yes or no, if yes, explain)

Vomiting and/ or Diarrhea? Y / N explain: \_\_\_\_\_

Normal Urination? Y / N explain: \_\_\_\_\_

Eating/ Drinking Normally? Y / N explain: \_\_\_\_\_

Activity Level Normal? Y / N explain: \_\_\_\_\_

Recent Injury or Accident? Y / N explain: \_\_\_\_\_

Limping? Y / N which leg: \_\_\_\_\_

Coughing/ Sneezing? Y / N explain: \_\_\_\_\_

Scratching/ Chewing at skin? Y / N explain: \_\_\_\_\_

\_\_\_\_\_

Weight Loss or Gain? Y / N explain: \_\_\_\_\_

Lumps/ Bumps? Y / N Location: \_\_\_\_\_

Behavioral Concerns? Y / N explain: \_\_\_\_\_

\_\_\_\_\_

Recent Surgeries: Y / N explain: \_\_\_\_\_

\_\_\_\_\_

Allergic Reactions to Medications: Y / N explain: \_\_\_\_\_

Vaccine Reactions: Y / N explain: \_\_\_\_\_

History or Seizures: Y / N explain: \_\_\_\_\_

Other

information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\*\*use back of sheet if needed\*\*\*