Animal Medical Care
984 Thompson Bridge Road
Gainesville, GA 30501
770-532-1217

Drop Off Form

Client Information

Date: _____

Client Name:_____

Client Phone Number: _____

Pet Information

Pets Name: _____

Please circle any of the following symptoms your pet is having and explain in the space provided.

Vomiting Diarrhea Constipation Coughing Sneezing

Ear Problems Eye Problems Skin Problems Itching/Scratching Limping

Frequent Urination Difficulty Urinating Lethargic Lack of Appetite Excessive Thirst

Explain Symptoms: _____

_____

How long has your pet been showing these symptoms: _____

Does your pet have any lumps/growths that need to be examined: _____

Date/Time of last meal:_____

Type/Brand of food your pet has been eating: _____

Date/Time of last normal bowel movement: _____

Date/Time of last urination: _____

Is your pet currently taking any medication: Yes / No

Current Medication(s) Type: _____

Date/Time of last medication(s) given: _____

Does your pet have any allergies? Yes / No

If yes, list allergies: _____

List any major medical history: _____

Do you give Animal Medical Care permission to sedate/anesthetize your pet? If yes, please sign below.

Client Signature: _____ Date: _____ AMC Staff Initials: _____