Curbside History Form

Name:_____

Pet's Name: _____

Cell phone: _____

Date: _____

Please have this form **completed** before coming to the hospital. You can email it back before your appointment or bring it with you. Your pet will be brought into the hospital by a team member, the doctor will do an exam and any questions/conversations will be by phone. Please have a cell phone ready and the number of that phone on this form. Payment of services will be curbside as well, and expected after the visit is complete.

Curbside appointment	Please arrive 10mins before your appointment time	If your pet is scheduled for a routine annual exam, we recommend yearly blood work and viral screening, fecals checked twice yearly and vaccines due updated. We will provide an estimate of what we have in our records that is needed for your pet for you to review when we come to your car.
Park	Please let us know where you have parked, the make, color and model of your car.	
Notifying us of your arrival	Please call our office once you have arrived	
Pet prepared	Please have your pet on a leash or in a carrier before we come to the car	Please bring a fecal and urine sample, so if needed it is available.

Question	Circle yes or no	Comments
Briefly describe the reason your pet is here for an exam, such as ear infection, sick or limping. Please answer all questions below regardless of why your pet is here.		
Has your pet had any coughing ?	Yes No	
Has your pet had any sneezing ?	Yes No	
Does your pet have any nasal discharge? If yes what color and which nostril(s)?	Yes No	
Has your pet been vomiting?	Yes No	
If your pet has been vomiting when was the last time and describe the vomit.		
Has your pet had diarrhea?	Yes No	
Does your pet's stool look normal in color? If no, is it black or bloody?	Yes No	
Has your pet been drinking more?	Yes No	
Has your pet been urinating more?	Yes No	
Have you seen your pet's urine? If so what was the color and amount?	Yes No	
Has your pet's appetite changed and if so describe how?	Yes No	
When was the last time you saw a bowel movement and what did it look like?		
Any change in diet? If yes, when and what did you change?	Yes No	
Is your pet lethargic (not active)? If yes, how long?	Yes No	
Is your pet here because it is limping? If so which leg and how long?	Yes No	
Please list all medications your pet is on and when they were last given:		
Has your pet cried out? If so what was your pet doing when this occurred?	Yes No	

Question	Circle yes or no	Comments
Does your pet have a problem with one or both of its eyes? Which eye, describe any drainage or symptoms.	Yes No	
Does your pet have a problem with one or both of its ears? Which ear, describe any discharge or symptoms.	Yes No	
Do you have a concern with your pet's teeth? If yes, describe.	Yes No	
Would you like your pet's nails trimmed while here? Comment if any concerns with the nails.	Yes No	
Would you like your pet's anal glands emptied? Comment if any concerns with them, any scooting or licking?		
Are there any new lumps or bumps you have found? If so, where are they and how long have they been present?	Yes No	
Please use the rest of the sheet to write any information that you feel would be helpful in treating your pet today. We will do our best to have your pet seen and communicate a plan as quickly as possible.		