Primary Care Service - Wellness and Vaccine Drop Off Form

Client Name: ________________________________ Pet’s Name: ________________________________
Best number to reach you today: ____________________________ Best time: ___________________

*We will call to get authorization prior to any treatment or diagnostics unless otherwise indicated!*

Has your pet been seen by us before? [  ] Yes [  ] No (if not, please fill out a Client Registration form)
When was your pet’s last meal? ___________ What did he/she eat? ________________

What medications (if any) has your pet received in the last 24 hours?

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<th>Name of medication:</th>
<th>Amount given</th>
<th>What time</th>
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Is your pet sensitive or allergic to any medications or food  [  ] no  [  ] yes  (please list)

What vaccinations, if needed, would you like us to give your pet today?

[  ] Rabies
[  ] Distemper-Parvo [  ] Lepto [  ] Kennel Cough
[  ] Feline upper respiratory (RCP) [  ] Feline Leukemia

Has your pet ever had a vaccine reaction (facial swelling, hives, vomiting, difficulty breathing)?

Please describe any problem(s) your pet is having, pertinent history leading up to the current condition, and any previous major medical problems:

________________________________________________________________________________

________________________________________________________________________________

In admitting my pet(s) for diagnostics, treatment, or surgery, I authorize the veterinarians in TAMU Primary Care, and their support staff, to administer such treatment and/or perform such diagnostic or surgical procedures as deemed necessary.

Signed: ________________________________ Date: __________________________