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 and get authorization prior to any treatment or diagnostics!*

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?

<table>
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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: ________________________