

ILLNESS ADMISSION FORM

**In order to provide you pet with the best possible care, an accurate history and description of your pets' symptoms is very important. We thank you in advance for taking the time to fill out the information below.

Date: _____.

Owner's Name: _____ Pet's Name: _____.

What is your pet coming in for today:

How long has the problem been going on? _____

Appetite:	<input type="checkbox"/> Normal	<input type="checkbox"/> Poor	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Excessive		
Thirst:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> None		
Urination:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Decreased	<input type="checkbox"/> Straining	<input type="checkbox"/> Bloody	
Stools:	<input type="checkbox"/> Normal	<input type="checkbox"/> Hard	<input type="checkbox"/> Soft	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Straining	<input type="checkbox"/> Bloody
Respiration:	<input type="checkbox"/> Normal	<input type="checkbox"/> Increased	<input type="checkbox"/> Coughing	<input type="checkbox"/> Sneezing		
Vomiting:	<input type="checkbox"/> Normal	<input type="checkbox"/> Food	<input type="checkbox"/> Mucus	<input type="checkbox"/> Bile	<input type="checkbox"/> Blood	

Has the problem changed? Improved Worsened Remained the same

Have you treated your pet at home (including any over-the-counter medication) for this problem? No Yes

If so, please describe: _____

What do you feed your pet? _____

When did your pet last eat? _____

When did your pet last drink? _____

Is your pet taking any medications? No Yes

If so, please list medications and doses: _____

If your pet is under treatment for diabetes, what time was the last insulin injection given? _____

How many units? _____

Permission for Diagnostics and Treatment. Please read before signing.

If we find the need for diagnostic labwork or x-rays, would you like us to:

Perform the procedures Contact you with an estimate (Phone#: _____)

If your pet requires surgical/anesthetic procedures, would you like us to:

Perform the procedures Contact you with an estimate (Phone#: _____)

I permit Animal Medical Center to treat my pet within the above guidelines.

Signature: _____ Date: _____

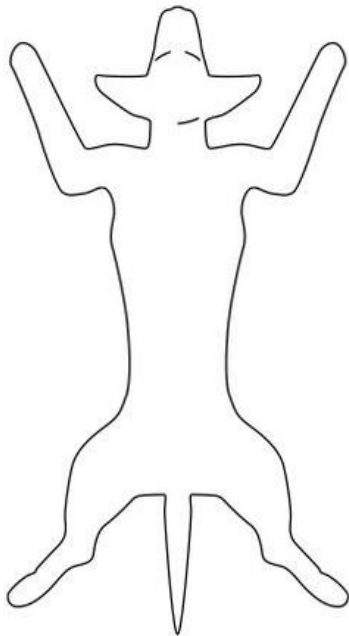
Home #: _____ Cell #: _____ Work #: _____

Please indicate your preferred contact number: _____

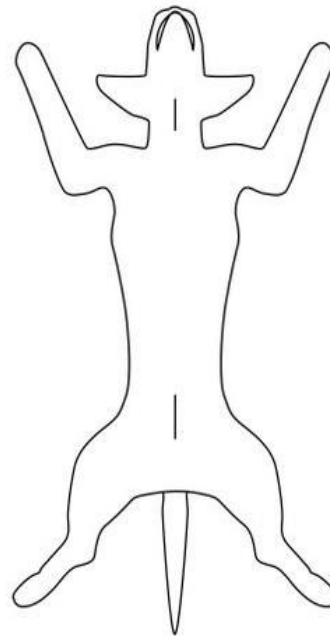
Please describe in your own words what seems to be the problem and circle the body part on the diagram that you think is the problem. If you are concerned about a mass or growth, please note when you first noticed area of concern and if it has increased in size.

Please note any problem areas below.

Left (Top side) Right



Right (Bottom side) Left



*For your pet's protection, all vaccines must be current. Your pet must be free of external parasites.
If not, treatment will be done at your expense.*