



Indian Hills Animal Clinics

3223 W 13th St - Wichita, KS 67203 - Phone 942-3900 Fax 854-5456
1448 N Maize Rd - Wichita, KS 67212 - Phone 722-6444 Fax 854-5456

PATIENT DAY ADMITTANCE FORM

Date: _____

To help us do a thorough job examining and/or treating your pet, please provide the following information. Please print.

Owner's Name: _____ Patient's Name: _____

Telephone number(s) where you can be reached today _____

What time would you like to pick up your pet? _____

Would you like a call when your pet is ready to go home? Yes No

GENERAL HEALTH INFORMATION:

Is your pet microchipped? Yes No

Pet's Diet (Brand Name): _____ How much do you feed your pet daily: _____

Daily Environment: Indoors Only Outdoors only Indoors & Outdoors

Do you have any other pets? Yes No if yes, please list: _____

Does your pet spend time around any other animals? Yes No

Is your pet on any current medications or vitamins? *Not including Heartworm/Flea Prevention*

Yes, please list name, dose, and frequency No, my pet does not take any medications or vitamins

Medication #1: _____ Medication #2: _____ Medication #3: _____

Vitamins/Supplements: _____

What time and date did your pet last receive its medication (s)? _____

Is your pet on flea and heartworm preventative? Please check which one(s) your pet receives monthly.

Simparica Trio ProHeart NexGard Simparica Frontline Plus Revolution
 Other: _____

Does your pet have any allergies or drug reactions? Yes, please explain _____ No

Appetite: Normal Increased Decreased

Water consumption: Normal Increased Decreased

Bowel Movement: Normal Abnormal

Urination: Normal Increased Decreased

Please explain if needed: _____

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TODAY'S MEDICAL CONCERNS:

Please check any symptoms/medical concerns you have seen.

<p>Appearance: <input type="checkbox"/> Lethargic, depressed <input type="checkbox"/> Losing weight <input type="checkbox"/> Weight gain</p> <p>Eyes: <input type="checkbox"/> Abnormal discharge <input type="checkbox"/> Scratching at <input type="checkbox"/> Abnormal growth</p> <p>Ears: <input type="checkbox"/> Itching/scratching <input type="checkbox"/> Redness/inflammation <input type="checkbox"/> Abnormal odor <input type="checkbox"/> Abnormal discharge</p> <p>Skin: <input type="checkbox"/> Itching/scratching/licking <input type="checkbox"/> Hair loss <input type="checkbox"/> Scooting <input type="checkbox"/> Tumor or growth <input type="checkbox"/> Redness/inflammation <input type="checkbox"/> Wound <input type="checkbox"/> "Hot Spot"</p> <p>Gastrointestinal: <input type="checkbox"/> Anorexia <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in Stool</p> <p>Musculoskeletal: <input type="checkbox"/> Lameness or Limping <input type="checkbox"/> Pain</p> <p>Nervous System: <input type="checkbox"/> Abnormal behavior <input type="checkbox"/> Seizures</p> <p>Urogenital: <input type="checkbox"/> Urinating frequently <input type="checkbox"/> Not urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinating in unusual places</p>
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Specify concerns (i.e. limping on left leg, growth on forehead, green left eye discharge):

Duration of concerns (i.e. hours, days, weeks, months): _____

Has your pet eaten within the last 12 hours? Yes No

Any additional comments?:

In addition to a physical examination, we may need to run tests or do other procedures to achieve an accurate diagnosis. We will make every effort to contact you at the above number(s) if any additional procedures or tests may be necessary. Your animal will be seen at our earliest convenience during our hospital schedule. Our goal is to give your pet the best possible medical care available. **I give the doctors of Indian Hills Animal Clinics permission to examine my pet and I understand that I am responsible for payment of services at the time of dismissal of my pet.**

Pet Owner/Agent: _____

Date: _____