INDIAN HILLS ANIMAL CLINIC

8650 W. Central Ave – Wichita KS 67212 – Phone: 942-3900

PATIENT DAY ADMITTANCE FORM

TO HELP US DO A THOROUGH JOB EXAMINING AND/OR TREATING YOUR PET, PLEASE PROVIDE THE FOLLOWING INFORMATION. PLEASE PRINT.

Date: _____

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 or a text when your pet is ready to go home? ☐ Text ☐ Call

GENERAL HEALTH INFORMATION:

Pet's Diet (brand name): _____ How Often: _____ Last Meal: _____

Daily Environment: ☐ Indoors Only ☐ Outdoors Only ☐ Indoors & Outdoors

☐ Enclosed Glass ☐ Free Roam ☐ Wire

Environmental Details: Type of Substrate:_____ Type of Lighting:_____

Heat Source:_____ Humidity in Enclosure:_____

Soaking Dish? ☐ Yes ☐ No Last Shed:_____

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

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

Housed with other pets? ☐ Yes ☐ No

Is your pet on any other medications or vitamins?

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

Medication Name #1: _____ Dose / Frequency: _____

Medication Name #2: _____ Dose / Frequency: _____

Medication Name #3: _____ Dose / Frequency: _____

Vitamins / Supplements: _____

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

APPETITE AND HABITS

Appetite:	☐ Normal	☐ Increased	☐ Decreased
Water Consumption:	☐ Normal	☐ Increased	☐ Decreased
Bowel Movement:	☐ Normal	☐ Abnormal	
Urination:	☐ Normal	☐ Increased	☐ Decreased

PLEASE EXPLAIN IF NEEDED:

_____

_____

CONTINUE ON BACK →

TODAY'S MEDICAL CONCERNS:

PLEASE CHECK ANY SYMPTOMS / MEDICAL CONCERNS YOU HAVE SEEN.

APPEARANCE:

□ Lethargic / Depressed □ Losing Weight □ Weight Gain

EYES:

□ Abnormal Discharge □ Scratching Eyes □ Abnormal Growth

EARS:

□ Itching / Scratching □ Redness / Inflammation □ Abnormal Odor □ Abnormal Discharge

SKIN:

□ Itching / Scratching / Licking □ Hairloss □ Scooting □ Tumor or Growth

□ Redness / Inflammation □ Wound □ "Hot Spot"

GASTROINTESTINAL:

□ Anorexia □ Vomiting □ Diarrhea □ Constipation □ Blood In Stool

MUSCULOSKELETAL:

□ Lameness / Limping □ Pain

NERVOUS SYSTEM:

□ Abnormal Behavior □ Seizures

UROGENITAL:

□ Urinating Frequently □ Not Urinating □ Blood In Urine □ Urinating In Unusual Places

SPECIFY CONCERNS (I.E. LIMPING ON LEFT LEG, GROWTH ON FOREHEAD, GREEN LEFT EYE DISCHARGE):

_____

_____

_____

_____

_____

_____

Duration of Concerns (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 Clinic permission to examine my pet and I understand that I am responsible for payment of services at the time of dismissal of my pet.

SIGNATURE: _____ DATE: _____