Day Admission Form
Medical Concern

Patient Name: _____

Owner: _____ Preferred Contact Number:_____

Secondary Contact: _____ Secondary Contact Number: _____
Preferred method of contact: text phone call

During the day it is very important that our veterinary staff is able to reach the person responsible for making decisions for your pet today. Be aware the call may come from a restricted line.

Medical History

Current Diet and Time of Last Meal: _____
Stools: ☐ Normal ☐ Abnormal Describe:_____
Urinary Habits: ☐ Normal ☐ Abnormal Describe:_____
Energy Level: ☐ Normal ☐ Abnormal Describe:_____
Water Intake: ☐ Normal ☐ Increased ☐ Decreased
Food Intake: ☐ Normal ☐ Increased ☐ Decreased Time of last meal:_____
Current medications & Time of Last Dose: (include over-the-counter, flea, tick and heartworm meds)
_____
_____

Describe today's concern in detail and answer the questions pertaining to your pet's clinical signs listed in the boxes below. _____
_____
_____

VOMITING / DIARRHEA

Has your pet been vomiting? ☐ **Yes** ☐ **No** How Long? _____ How Often?: _____
Color: _____ Substance: _____ Last Vomit: _____
Is it possible your pet ate something other than his/her regular food? ☐ **Yes** ☐ **No**
Describe: _____ The vomiting is: ☐ getting better ☐ getting worse ☐ about the same
Does your pet have diarrhea? ☐ **Yes** ☐ **No** How Long?_____ How Often? _____
Consistency (circle one): SOFT / LOOSE / LIQUID Bloody? ☐ **Yes** ☐ **No**
The diarrhea is: ☐ getting better ☐ getting worse ☐ about the same

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COUGHING / SNEEZING / EYE DISCHARGE / EAR INFECTION

Has your pet been coughing? ☐ **Yes** ☐ **No** How Long? _____ How Often?: _____
Describe cough: _____
Has your pet been sneezing? ☐ **Yes** ☐ **No** How Long? _____ How Often?: _____
Any discharge from the nose? ☐ **Yes** ☐ **No** Describe color/consistency: _____
Any eye discharge? ☐ **Yes** ☐ **No** Which eye? RIGHT / LEFT / BOTH
Describe: _____
Any ear pain? ☐ **Yes** ☐ **No** Which ear? RIGHT / LEFT / BOTH
Describe:_____

LIMPING / PAIN / SKIN ISSUES

Date of Onset: _____ Which body part is affected? _____
Is this due to a specific incident ☐ **Yes** ☐ **No** Describe:_____
Has your pet been treated for this problem in the past? ☐ **Yes** ☐ **No** Describe:_____
The lameness/pain: ☐ getting better ☐ getting worse ☐ about the same

Is your pet itching/scratching? ☐ **Yes** ☐ **No** Describe:_____
Currently on flea/tick prevention? ☐ **Yes** ☐ **No** What brand? _____
Any new lumps or bumps that are concerning? ☐ **Yes** ☐ **No**
Using the diagram below, please circle the body part that seems to be the problem.
Place an X on the diagram at the location of any lumps that you want checked/biopsied.

(Belly facing up) (Back facing up)

Additional Authorizations

In addition to the Office Visit fee ($55.95)
I authorize ☐ $200-$300 ☐ $300-$500 ☐ Other $_____ for procedures done today.
I give my permission for All Pets to examine my pet today and perform any emergency procedures necessary to stabilize my pet in the case of an emergency.

******If you DO NOT want us to perform life-saving measures before authorization, please initial:*** _____

I understand that if my pet is found to have fleas they will be treated at my expense._____

Signature: _____ Date: _____

Staff use only

Staff Initials: _____ Patient weight:_____ Kennel number: _____ Scheduled D/A Time: _____