



Admissions Examination Form



First Name: _____ **Last Name:** _____ **Date:** _____

Telephone number where you may be reached today: _____

Alternate contact person and telephone phone number: _____

Preferred pick up time? _____

(Efforts are made to accommodate your needs – please call our office two hours after your drop off time to check on your pet’s status if a staff member has not contacted you: (760) 729-3330.

Pet’s Name: _____ **Species:** _____ **Breed:** _____ **Sex:** _____ **Color:** _____ **Age:** _____

History / Current medications: _____

Have medications been given today? Y / N If yes, list: _____

Any allergies to any vaccinations or medications? _____

Current Diet: _____ How Much: _____ How Often: _____

Did your pet eat this morning? Y / N Regular diet or other: _____

Appetite: (circle one) Normal / Increased / Decreased / Other: _____

Does your pet get table foods? Y / N Food Allergies? Y / N If yes, please list _____

Is he/she current on vaccines that have been administered at a different location or clinic? Y / N If yes, where _____

If no, would you like us to update your pet’s vaccine status? Y / N

Is your pet on monthly heartworm prevention? Y / N Product: _____

Is your pet on monthly flea/tick prevention? Y / N Product: _____

Why are you here today: _____

If you’re your pet is ill, your main concern is: _____

Has your pet ever been treated for this condition before? Y / N

When was this condition first noticed and/or first reappear _____

Please check ANY symptoms or problems you have noticed about your pet:

- | | | |
|---|--|--|
| <input type="checkbox"/> Behavior Changes | <input type="checkbox"/> Discharges, explain _____ | <input type="checkbox"/> Head shaking |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Gagging | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Limping, which leg _____ | <input type="checkbox"/> Urination problem _____ |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Scooting | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Weakness | |

I would like the following services performed during <animal>’s visit today:

- Nail trim
- Anal gland expression
- Ear wipe
- Bath

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT: As the owner or responsible party for the above patient, I authorize Mohnacky Animal Hospitals, Inc. to examine my pet and administer treatment, including medical procedures, administration of anesthesia, surgical procedures and diagnostic tests that in their judgment are consider reasonable and necessary. I understand that with any medical or surgical procedures there are always risks involved, including death, and that no warranty or guarantee is being made as to the results or cure. I assume full financial responsibility for all charges incurred and will pay in full for these services upon release of the patient. I have read and understand the above authorization for care and financial responsibility.

I understand that some pets require sedation/general anesthesia for adequate physical examination, treatment, or surgery. By signing below, I understand that there is risk involved with an animal is sedated.

Name Date

Employee Date

12/2016