American Animal Hospital

Medical Case Check-In

DATE: _____________

Pet NAME: ________________________ OWNER: ________________________ ACCT # __________

WEIGHT: __________ PREVIOUS WEIGHT: ___________

CHANGE IN ADDRESS? Y/ N ____

CHANGE IN PHONE? Y/ N ______________________ CURRENT EMAIL:_________________________

PRIMARY COMPLAINT(S): 1. _______________________________________

2. _______________________________________

3. ____

APPETITE: Normal Increased Decreased

VOMITING? Y/ N ___________________________If yes, Date Began:______________________________

DIARRHEA: Y/N ____________________________If yes, Date Began:______________________________

FOOD BRAND: _________________________ TREATS y/n: _____________Type:____________________

WATER INTAKE: Increased Decreased No Change

COUGHING: Y/ N ___________________________If yes, Date Began:______________________________

ACTIVITY: Normal Decreased Increased

CURRENT MEDS: 1. _______________________ 2. _________________________

3. _______________________ 4. _________________________

MISSED ANY DOSES OF FLEA PREVENTION: Y/ N

(CANINE) MISSED ANY DOSES OF HEARTWORM PREVENTION: Y/ N

Any other symptoms of concern:____

Do you authorize Lab Tests or Radiographs if Doctor needs diagnostics? Y or N

If understand that I am financially responsible for any costs associated with today’s visit that must be paid in full before leaving the hospital parking lot**. Y or N.**

Signature: ____________________________________