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schulhofanimalhospital.com

Hospital Sick/Injured Pet Admission Form

PLEASE NOTE: Payment is **required** at time of discharge.

Owner's Name: _____ Contact Number: (_____) _____ - _____

Pet's Name: _____ Species: **Canine** **Feline**

Would you like to be contacted by a doctor prior to beginning treatment? **Yes** **No**

If we are unable to reach you at the phone number specified above, would you like us to:

Begin tests and/or treatments **Perform only tests/procedures selected below** **Do nothing until notified**

I authorize Schulhof Animal Hospital to perform the following:

Exam Blood work Urinalysis Fecal test X-rays Ultrasound Rabies Vax Wound Care

Chief Complaint: _____

General information

Describe your pet's diet: _____

Appetite: Normal Excessive Poor Absent **Last time pet was fed:** _____

Water Consumption: Normal Increased Decreased **Energy Level:** Normal Increased Decreased

Coughing: Yes No **Sneezing:** Yes No **Exposed to any other animals:** Yes No

Please list any medications and when they were last given: _____

Gastrointestinal Problems

Is your pet vomiting: Yes No **If 'YES', how often:** _____ **Last Episode:** _____

What is your pet vomiting: Food Water Bile Hairballs Other _____

How would you describe your pets recent bowel movements: (select all that apply)

Normal Hard Soft Diarrhea Constipated Bloody Mucous Unsure

When was your pets last bowel movement: _____ **Frequency of Bowel Movements:** _____

Could your pet have eaten something abnormal or food not typical in their normal diet: Yes No

If 'YES', what: _____

Musculoskeletal Problems

How would you describe your pets symptoms: (select all that apply)

Lameness Neck Pain Back Pain Painful area Swelling

Does your pet have: Difficulty walking down stairs Difficulty walking up stairs Trouble standing up

Is your pet's condition: Constant Intermittent **Is it:** Worse after exercise Worse after resting

Has your pet been licking or biting at a specific area: Yes No **If 'YES', where:** _____

How long has your pet had the above condition(s): _____

Additional Info: _____

Urinary Problems

How would you describe your pet's current urinary behavior: (select all that apply)

- Normal Bloody Change In Odor Straining Incontinent Weak Stream
Increased Frequency Decreased Frequency Increased Volume Decreased Volume

When did your pet last urinate: _____ How frequently does your pet urinate: _____

Additional Info: _____

Ear Problems

How would you describe your pet's current ear condition(s) : (select all that apply)

- Red Dirty Waxy Foul Odor Itchy Oozing Bleeding Swollen Wound

Have you noticed these conditions in your pet's: Left Ear Right Ear Both Ears

Is your pet shaking their head: Yes No Scratching or Rubbing their ears: Yes No

Additional Info: _____

Eye Problems

How would you describe your pet's current eye condition(s) : (select all that apply)

- Red Discharge Swollen Squinting Itchy Bleeding Rapid eye movements

Have you noticed these conditions in your pet's: Left Eye Right Eye Both Eyes

How long has your pet had the above condition(s): _____

Additional Info: _____

Skin Problems

How would you describe your pet's current skin condition(s) : (select all that apply)

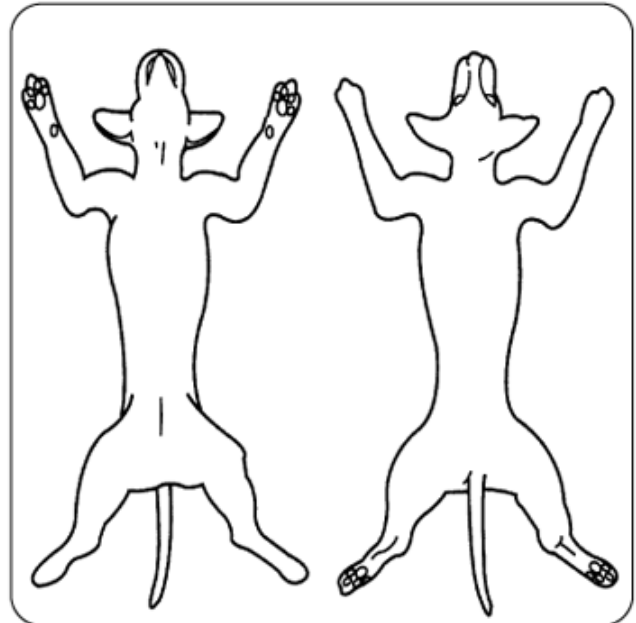
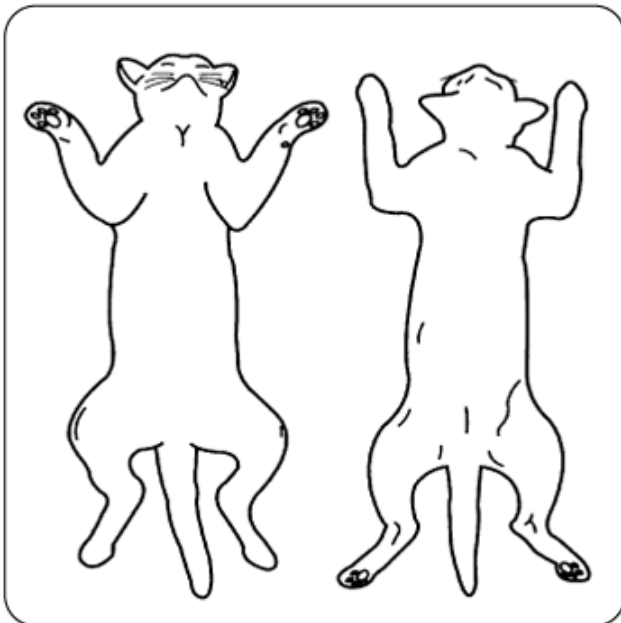
- Normal Itchy Red Oozing Wound Bleeding Rash Dry/Flaky Smelly

Is there lump or growth: Yes No If 'YES', has it changed in size: Larger Smaller Same

How long has your pet had the above condition(s): _____

Please illustrate on the anatomical chart below where the lump(s) / growth(s) / skin condition(s) are located.

Additional Info: _____



Date _____

Signature of Owner or Responsible Party