# Asheville Highway Animal Hospital

**4516 Asheville Highway**
**Knoxville, TN 37914**
**865-523-8434**

- Date:_____
- Pet's Name:_____ Client's Name:_____ Account #: _____
- Phone Number for Today: _____ Person to Ask For: _____
- How would you like to be contacted today? (Check all that apply.) ☐ Call ☐ Text ☐ AHAHVet Chat ☐ Email:_____
- Preferred Pick-up Time: ☐ **M-F** between 1:00-3:00pm ☐ **M-F** between 3:00-5:00pm ☐ **Sat** between 1:00-1:40pm** ☐ Anytime
- Are you the owner? ☐ Yes ☐ No
- Is Your Pet Primarily: ☐ Indoor or ☐ Outdoor
- Is Your Pet on Medication? ☐ Yes or ☐ No If so, please list medication and reason:

  _____

- Food (please include type, brand, & amount, including treats and table food). What has your pet eaten in the last 48 hours (dog food/ foreign objects/table food/treats)?:

  _____

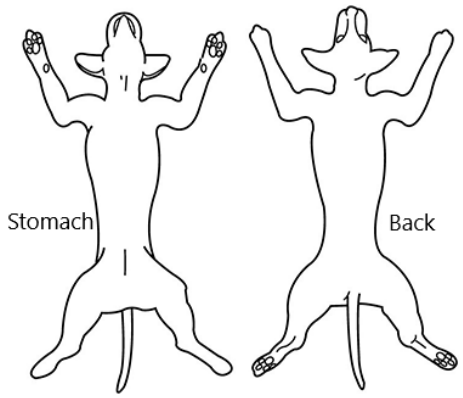
****We close at 2:00pm on Saturday.**

- **Please check all symptoms that apply to your pet:**

| | | |
|---|---|---|
| ☐ **No Problems** | | |
| ☐ **Change in Behavior** | ☐ **Hair Loss*** | ☐ **Scratching*** |
| ☐ **Constipation** | ☐ **Increased Appetite** | ☐ **Seizures** |
| ☐ **Coughing** | ☐ **Increased Water Intake** | ☐ **Shaking Head** |
| ☐ **Decreased Appetite** | ☐ **Lethargic** | ☐ **Straining to Urinate** |
| ☐ **Decreased Water Intake** | ☐ **Limping** | ☐ **Vomiting** |
| ☐ **Depressed** | ☐ **Odor** | ☐ **Watery Eyes** |
| ☐ **Diarrhea*** | ☐ **Pain** | ☐ **Weakness** |
| ☐ **Difficulty Breathing** | ☐ **Panting** | ☐ **Weight Gain** |
| ☐ **Discharge** | ☐ **Rash*** | ☐ **Weight Loss** |
| ☐ **Frequent Urination** | ☐ **Redness*** | ☐ **Worms Seen** |
| ☐ **Gagging** | ☐ **Restlessness** | |
| ☐ **Growths** | ☐ **Scooting** | |

** Additional Information Requested---Please Fill Out Questionnaire on Back of Form

**Please describe in further detail any symptoms marked above, include location:**




- How long has your pet had these symptoms? _____
- If this a follow up visit, is the pet better or are there new issues? _____
- Are there any other animals in your household that are sick? _____

**Our Staff will contact you at the number above with an estimate of charges.**

## Dermatology History

1. What age did you first notice the problem?_____
2. Is the problem year round or worse during a particular time of year?

   □ Year Round □ Winter □ Spring □ Summer □ Fall
3. What did the problem look like when it first started?

   □ Scratching □ Hair Loss □ Rash Redness □ Other _____
4. Where did it start?

   □ Nose □ Eyes □ Ears □ Neck □ Back □ Rump

   □ Legs □ Paws □ Chest □ Stomach □ Groin □ Tail
5. Any other pets or people with skin issues in your home? □ Yes □ No

   If yes, please describe: _____
6. Your pet spends its time:_____% Indoor _____ % Outdoor
7. Has there been a change in diet? □ Yes □ No

   If yes, please describe: _____
8. Is your pet of Flea medication? □ Yes □ No

   If yes, please describe: _____

## Gastrointestinal History

1. Is your pet vomiting? □ Yes □ No

   If yes, please describe:_____

   How often?_____

   When did this first occur? _____

   When did this last occur? _____
2. Does your pet have diarrhea? □ Yes □ No

   If yes, please describe: _____

   How often? _____

   When did this first occur? _____

   When did this last occur? _____
3. Please describe anything your pet may have eaten in the last 24 hours (food, treats, table food, etc.)

   _____
4. Are there any other animals in your home that are sick? □ Yes □ No

   If yes, please explain: _____
5. Is there anything your pet could have gotten into? □ Yes □ No

   If yes, please explain: _____
6. Is your pet monitored outside? □ Yes □ No