



**Avian and Exotic Pet Service**  
 Lauren V Powers, DVM, DABVP (Avian Practice)  
 Board-Certified in Avian Medicine and Surgery

<b>Date:</b>	
<b>Time:</b>	
<b>Appt Type:</b>	<input type="checkbox"/> Wellness <input type="checkbox"/> Sick Visit <input type="checkbox"/> Work-In <input type="checkbox"/> After-Hours ER

## EXOTIC COMPANION MAMMAL - HISTORY QUESTIONNAIRE

Thank you for trusting us with your pet's veterinary care. Please help us to better serve you and your pet by completing this questionnaire to the best of your ability. Leave sections blank if you do not know the answer.

<b>Client's name</b>		<b>Pet's date of birth</b>	
<b>Pet's name</b>		<b>Date pet was obtained</b>	
<b>Species</b>		<b>Age when obtained</b>	
<b>Breed and color</b>		<b>Sex</b>	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown <input type="checkbox"/> Spayed/Neutered
<b>Place pet obtained</b>	<input type="checkbox"/> Pet store Name: _____ <input type="checkbox"/> Breeder Name: _____	<input type="checkbox"/> Friend or family member <input type="checkbox"/> Found outside <input type="checkbox"/> Born at home	<input type="checkbox"/> Former owner (not family member) <input type="checkbox"/> Other: _____
<b>How did you hear about us?</b>	<input type="checkbox"/> Internet <input type="checkbox"/> Phone book <input type="checkbox"/> Personal reference <input type="checkbox"/> Pet store <input type="checkbox"/> Breeder <input type="checkbox"/> Veterinary referral		
<b>If referred, please list referring vet and hospital</b>			

### HOUSING AND ENVIRONMENT

<b>Style of cage (check all)</b>	<input type="checkbox"/> Purchased <input type="checkbox"/> Came with pet <input type="checkbox"/> Homemade (galvanized wire, C&C, etc) <input type="checkbox"/> None (not caged) <input type="checkbox"/> Glass <input type="checkbox"/> All wire <input type="checkbox"/> Plastic bottom, wire top <input type="checkbox"/> All plastic <input type="checkbox"/> Wood and wire <input type="checkbox"/> All wood	Other: _____
<b>Cage dimensions</b>	Height: _____ Width: _____ Depth: _____	<input type="checkbox"/> Unknown
<b>Cage location in home</b>	<input type="checkbox"/> Family room <input type="checkbox"/> Living room <input type="checkbox"/> Bedroom <input type="checkbox"/> Dining room <input type="checkbox"/> Outside <input type="checkbox"/> Indoor/outdoor <input type="checkbox"/> Screened-In Porch <input type="checkbox"/> Sunroom <input type="checkbox"/> Outside <input type="checkbox"/> Quarantine area <input type="checkbox"/> Kitchen	Other: _____
<b>Water containers (check all)</b>	<input type="checkbox"/> Water bottle <input type="checkbox"/> Water bowl <input type="checkbox"/> Both <input type="checkbox"/> Multiple	Other: _____
<b>Type of litter</b>	<input type="checkbox"/> Pine shavings <input type="checkbox"/> Aspen shavings <input type="checkbox"/> Cedar shavings <input type="checkbox"/> Hemp shavings <input type="checkbox"/> Newspaper <input type="checkbox"/> Recycled newspaper pellets <input type="checkbox"/> Paper (eg. CareFresh) <input type="checkbox"/> Fleece or fabric	Other: _____
<b>Is there a grate (wire) on the bottom of the cage?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Taken outdoors?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Exercise pen/area available?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Allowed time out of cage? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, how often?</b>
<b>Level of supervision</b>	<input type="checkbox"/> Always watched <input type="checkbox"/> Unsupervised on occasion <input type="checkbox"/> Troublemaker <input type="checkbox"/> Never out of cage	
<b>Is your pet bathed?</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never (fearful)	

### DIET AND SUPPLEMENTS

<b>Purchased diets (pellets or mix) or homemade diets</b>	<b>Brand(s):</b> _____ <b>Amount per feeding:</b> _____	<b>Frequency that formulated diets are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
<b>Hay (rabbits and rodents)</b>	<input type="checkbox"/> Western timothy <input type="checkbox"/> Orchard grass <input type="checkbox"/> Alfalfa <input type="checkbox"/> Oat <input type="checkbox"/> Bermuda	<b>Frequency that hay is offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
<b>Green leafy vegetables and herbs (rabbits, rodents, sugar gliders)</b>	<input type="checkbox"/> Kale <input type="checkbox"/> Collards <input type="checkbox"/> Spinach <input type="checkbox"/> Parsley <input type="checkbox"/> Cilantro <input type="checkbox"/> Green leaf, red leaf, or romaine lettuce <input type="checkbox"/> Chard <input type="checkbox"/> Iceberg lettuce <input type="checkbox"/> Mustard greens <input type="checkbox"/> Cabbage <input type="checkbox"/> Bok choy <input type="checkbox"/> Turnip greens <input type="checkbox"/> Dandelion greens <input type="checkbox"/> Watercress <input type="checkbox"/> Carrot tops <input type="checkbox"/> Mint <input type="checkbox"/> Basil <input type="checkbox"/> Other: _____	<b>Frequency that green leafy vegetables are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
<b>Other vegetables (rabbits, rodents, sugar gliders)</b>	<input type="checkbox"/> Carrots <input type="checkbox"/> Sweet potatoes <input type="checkbox"/> Cauliflower <input type="checkbox"/> Pepper <input type="checkbox"/> Green beans <input type="checkbox"/> Squash <input type="checkbox"/> Zucchini <input type="checkbox"/> Broccoli <input type="checkbox"/> Other: _____	<b>Frequency that other vegetables are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
<b>Fruits (rabbits, rodents, sugar gliders)</b>	<input type="checkbox"/> Strawberries <input type="checkbox"/> Bananas <input type="checkbox"/> Grapes <input type="checkbox"/> Papaya <input type="checkbox"/> Mango <input type="checkbox"/> Apple <input type="checkbox"/> Citrus (orange, lime, etc) <input type="checkbox"/> Other: _____	<b>Frequency that fruits are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
<b>Cereals, grains, seeds, nuts (rabbits, rodents, sugar gliders)</b>	<input type="checkbox"/> Rolled oats <input type="checkbox"/> Dried corn <input type="checkbox"/> Sunflower seeds <input type="checkbox"/> Pumpkin seeds <input type="checkbox"/> Nuts <input type="checkbox"/> Cereal <input type="checkbox"/> Groats <input type="checkbox"/> Other: _____	<b>Frequency that grains are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted

**OVER »**

<b>Supplements</b>	<input type="checkbox"/> Vitamin C tablets <input type="checkbox"/> Vitamin C in the drinking water <input type="checkbox"/> Multi-vitamins <input type="checkbox"/> Hay blocks or cubes <input type="checkbox"/> Joint care <input type="checkbox"/> Other:	<b>Frequency that supplements are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
<b>Treats</b>	<input type="checkbox"/> Yogurt drops <input type="checkbox"/> Fruit <input type="checkbox"/> Grains <input type="checkbox"/> Cereals <input type="checkbox"/> FerreTone <input type="checkbox"/> FerretVite <input type="checkbox"/> Mealworms <input type="checkbox"/> GliderAid <input type="checkbox"/> Other:	<b>Frequency that treats are offered</b>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted

**PREVIOUS MEDICAL HISTORY**

<b>Any cage mates? Describe:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, are they healthy? If not, please describe:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Other PETS in the home? Describe:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Previous wellness examinations?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Previous vaccinations (FERRETS ONLY)?</b>	<b>Rabies</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   Last date: <b>Canine Distemper</b> <input type="checkbox"/> Yes <input type="checkbox"/> No   Last date:
<b>Previous adverse drug reactions?</b>	
<b>Previous medical or surgical problems (please describe)</b>	

**BEHAVIOR AND PERSONALITY**

<b>How would you describe your pet? (Check all that apply)</b>	<input type="checkbox"/> Calm <input type="checkbox"/> Well-Socialized <input type="checkbox"/> Outgoing <input type="checkbox"/> Aggressive <input type="checkbox"/> High-Strung <input type="checkbox"/> Anxious <input type="checkbox"/> Phobic <input type="checkbox"/> Neurotic <input type="checkbox"/> Depressed <input type="checkbox"/> Lethargic	
<b>Have there been, or are there now, any of the following behavior problems?</b>	<input type="checkbox"/> Aggressive biting <input type="checkbox"/> Fear biting <input type="checkbox"/> Phobias or anxiety <input type="checkbox"/> Destructive <input type="checkbox"/> Depression <input type="checkbox"/> Repetitive behaviors	
<b>Check if your pet has, or has had, any symptoms in the following areas to a significant degree and briefly explain.</b>		
<input type="checkbox"/> Skin	<input type="checkbox"/> Airways or lungs	<input type="checkbox"/> <b>Recent changes in:</b>
<input type="checkbox"/> Fur	<input type="checkbox"/> Feces	<input type="checkbox"/> Body weight
<input type="checkbox"/> Toenails	<input type="checkbox"/> Urine	<input type="checkbox"/> Energy level
<input type="checkbox"/> Head or neck	<input type="checkbox"/> Lips	<input type="checkbox"/> Appetite
<input type="checkbox"/> Throat	<input type="checkbox"/> Legs	<input type="checkbox"/> Thirst
<input type="checkbox"/> Nasal passages or sinuses	<input type="checkbox"/> Behavior	<input type="checkbox"/> Voice

**CURRENT PROBLEM (IF APPOINTMENT IS FOR MEDICAL CONCERN)**

<b>Date that problem was first noticed:</b>	
<b>Please describe the problem:</b>	
<b>How has the problem changed?</b>	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Episodic <input type="checkbox"/> No better or worse <input type="checkbox"/> Unknown
<b>Current medication (if any) and response:</b>	<input type="checkbox"/> None
<b>How would you like us to handle and restrain your pet today? (check all that apply).</b>	<input type="checkbox"/> I wish to be present for exam and all procedures (eg. blood draw, grooming) <input type="checkbox"/> I wish to be present for exam only and not for any procedures (eg. blood draw) <input type="checkbox"/> I wish to leave the room while you work on my pet in the exam room <input type="checkbox"/> I am okay if you wish to take my pet to the Exotics Treatment Room
<b>Any special requests or concerns about how we handle and restrain your pet today?</b>	

**PLEASE DESCRIBE ANY ADDITIONAL QUESTIONS OR CONCERNS YOU MAY HAVE**

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