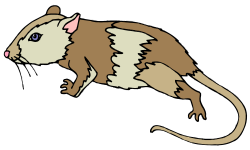

SMALL MAMMAL HISTORY FORM

Avian & Exotic Clinic
Of Palm City
Dr. April Romagnano
(772) 600-8895

Patient Info.

Pet's Name: _____ Client Name: _____ Date:_____

Species: **Guinea Pig / Chinchilla / Degu / Hamster / Gerbil / Rat / Mouse / Sugar Glider / Hedgehog / Other_____**

Sex: **M – F - Unsure** Neutered: **Yes – No - Unsure**

Is this your first small mammal? **Yes - No** First of this type? **Yes - No**
Date of birth _____ (Circle): **actual - estimate**

When did you get your pet? _____
Source: **Pet Store / Pet Show / Breeder / Private Party / Shelter / Other** _____

Environment

Approximate cage dimensions: H _____ x W _____ x L _____ or Gallons: _____
Substrate (Circle): **Care Fresh / Yesterday's News / Wood Shavings (cedar – pine) Hardwood Chips (aspen – walnut) / Newspaper / Other _____**
How often is the cage cleaned? _____

Cage Accessories: **Sleeping Box - House / Climbing Toys / Shelves - Levels**
Cage Toys: **Exercise Wheel / Play Tubes / Chew Toys / Other _____**
Is cage shared with another animal? **Yes – No** Species of cage mate:_____

Sex of cage mate: **M – F – Unsure** Neutered? **Yes – No - Unsure**
Other Pets in the Home: _____

Are they exposed to this pet? **Y – N** In what way? _____
How much time does your pet get out of its cage per day? _____minutes
Is your pet supervised when it is outside of its cage? **Yes (always) – Usually - No**

Nutrition

Diet (detail everything offered) _____
_____
List everything your pet eats: _____
_____
Vitamin & Mineral Supplements: _____

(There is a back)

SMALL MAMMAL HISTORY FORM

Avian & Exotic Clinic
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Medical History

List current medical problems / Primary Complaint: _____

_____

Current treatments or supplements: _____

_____

Please list any previous medical problems (dates & treatment)

_____

_____

Current Appetite: **Normal – Increased – Decreased – Anorexic**
Describe (duration, progression, severity): _____
Stools: **Color** _____ **Consistency** _____ **Amount** _____ **Frequency** _____
Urination: **Color** _____ **Frequency** _____ **Amount** _____
Have you noticed (Circle all that apply):
weight loss, weight gain, masses or lumps (where _____)
abnormal urination, abnormal stools, vomiting, other discharge _____
difficult breathing, coughing, sneezing, nasal discharge _____
excessive shedding, hair loss, itching, skin sores (where _____)
poor posture, head tilt, loss of balance, limping (which leg _____)
lethargy, inactivity, pain (where _____)
Describe other changes: _____
Previous Veterinary Visits: **Yes – No** Date of last visit _____
Doctor _____ Clinic _____
Phone _____ Records requested? **Y – N** Received? **Y – N**
Previous Lab Tests / Diagnostics: **Y – N** Date of Last Testing _____
Complete Blood Count O Chemistry Profile O Fecal Exam O Urinalysis O
Bacterial Culture O Radiograph (X-ray) O Other Tests _____
Results Requested? **Y – N** Received by Clinic? **Y – N**