



Date:

Time:

**Appt
Type:**

☐ Wellness ☐ Sick Visit
☐ Work-In ☐ 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.

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

HOUSING AND ENVIRONMENT

Style of cage (check all)	<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"/> 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:
Cage dimensions	Height:	Width:	Depth:	<input type="checkbox"/> Unknown
Cage location in home	<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:
Water containers (check all)	<input type="checkbox"/> Water bottle <input type="checkbox"/> Water bowl <input type="checkbox"/> Both <input type="checkbox"/> Multiple			Other:
Type of litter	<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:
Is there a grate (wire) on the bottom of the cage?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Taken outdoors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How much time spent out of cage?	# of Hours		<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never	
Level of supervision	<input type="checkbox"/> Always watched <input type="checkbox"/> Unsupervised on occasion <input type="checkbox"/> Troublemaker <input type="checkbox"/> Never out of cage			
Is your pet bathed?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never (fearful)			

DIET AND SUPPLEMENTS

Formulated diets or homemade diets	Brand(s): Amount per feeding:	Frequency that formulated diets are offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
Hay (rabbits and rodents)	<input type="checkbox"/> Western timothy <input type="checkbox"/> Orchard grass <input type="checkbox"/> Alfalfa <input type="checkbox"/> Oat <input type="checkbox"/> Bermuda	Frequency that hay is offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
Green leafy vegetables and herbs (rabbits, rodents, sugar gliders)	<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:	Frequency that green leafy vegetables are offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
Other vegetables (rabbits, rodents, sugar gliders)	<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:	Frequency that other vegetables are offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
Fruits (rabbits, rodents, sugar gliders)	<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:	Frequency that fruits are offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
Cereals, grains, seeds, nuts (rabbits, rodents, sugar gliders)	<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:	Frequency that grains are offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted

Supplements	<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:	Frequency that supplements are offered	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never, or not accepted
Treats	<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:	Frequency that treats are offered	<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							
Any cage mates? Describe:						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, are they healthy? If not, please describe:						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other PETS in the home? Describe:						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous wellness examinations?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous vaccinations (FERRETS ONLY)?		Rabies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last date:	Canine Distemper	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last date:
Previous adverse drug reactions?							
Previous medical or surgical problems (please describe)							

BEHAVIOR AND PERSONALITY			
How would you describe your pet? (Check all that apply)		<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	
Have there been, or are there now, any of the following behavior problems?		<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	
Check if your pet has, or has had, any symptoms in the following areas to a significant degree and briefly explain.			
<input type="checkbox"/>	Skin	<input type="checkbox"/>	Airways or lungs
<input type="checkbox"/>	Fur	<input type="checkbox"/>	Feces
<input type="checkbox"/>	Toenails	<input type="checkbox"/>	Urine
<input type="checkbox"/>	Head or neck	<input type="checkbox"/>	Lips
<input type="checkbox"/>	Throat	<input type="checkbox"/>	Legs
<input type="checkbox"/>	Nasal passages or sinuses	<input type="checkbox"/>	Behavior
<input type="checkbox"/>			Recent changes in:
<input type="checkbox"/>			Body weight
<input type="checkbox"/>			Energy level
<input type="checkbox"/>			Appetite
<input type="checkbox"/>			Thirst
<input type="checkbox"/>			Voice

CURRENT PROBLEM (IF APPOINTMENT IS FOR MEDICAL CONCERN)	
Date that problem was first noticed:	
Please describe the problem:	
How has the problem changed?	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Episodic <input type="checkbox"/> No better or worse <input type="checkbox"/> Unknown
Current medication (if any) and response: <input type="checkbox"/> None	
How would you like us to handle and restrain your pet today? (check all that apply).	<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
Any special requests or concerns about how we handle and restrain your pet today?	

PLEASE DESCRIBE ANY ADDITIONAL QUESTIONS OR CONCERNS YOU MAY HAVE