



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: _____

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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 **Chemistry Profile** **Fecal Exam** **Urinalysis**

Bacterial Culture **Radiograph (X-ray)** **Other Tests** _____

Results Requested? **Y** – **N** Received by Clinic? **Y** – **N**

