Small Mammal
New Patient History

Specialized Care for Avian & Exotic Pets
10882 Main St. Clarence, NY 14031
(716) 759-0144 fax (716) 759-0146

• This Visit

Date: _____Reason for visit today? _____

How did you hear about us (phone book, newspaper ad, pet store, etc.)? _____

Have you been referred by another veterinarian? Yes (Name of Vet: _____) No

** *If your veterinarian has officially referred your pet to us, so that we may maintain good working relationships, we will not be able to provide care for other pets you may own and request that you maintain routine care for this patient with your primary veterinarian.*

• Owner and Pet Identification

Owner's Name(s): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City, State, Zip:_____

E-mail: _____

Please select address you prefer for health reminders e-mail regular mail ☐ text

Emergency Contact and Phone Number: _____

Employer's Name: _____

Pet's Name: _____ Breed if Known: _____

Pet's Date of Birth or Age: _____Date Acquired: _____

Sex: *Male* *Female* *Unknown*

Where was the pet obtained: Pet Store Animal Shelter Breeder Rescue Group Other

Color: _____

• Diet

Pelleted Food (include brand name and amount fed daily _____

_____

Please list any "table foods" and treats fed and amount fed daily: _____

_____

Fruits and Vegetables (please list type(s) and amount fed daily): _____

_____

Hay (please list types and amount fed daily): _____

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Do you give your pet vitamins or other supplements? *Yes* *No*

If yes, please list:_____

How is water offered? *Bowl* *Bottle* *Tap water* *Bottled* *Filtered*

- Housing and Environment

Is your pet housed? *Caged* *Free in house*

How much out of cage time does your pet have daily? _____

What type of bedding does your pet have? *Cedar shavings* *Pine shavings* *Aspen shavings*

Towels *Carefresh* *Cat Litter* *None* *Other:* _____

How often is the cage cleaned? _____

What is used to clean the cage? (e.g. white vinegar, etc.) _____

Do you have other pets? _____

If yes, are they housed in the same cage? *Yes* *No*

List any other pets in the home: _____

Have any other pets been sick or have any died in the last 12 months? ***Y/N***

- Previous Medical History

Has your pet had any previously diagnosed illness? *Yes* *No*

If yes, please describe _____

Has your pet had any laboratory tests performed? *Yes* *No*

If, yes please circle: *Blood work* *Fecal exam* *X-rays* *Other* _____

Has your pet ever had surgery? *Yes* *No*

If yes, please describe _____

Have You Noticed?

___Decreased or loss of appetite
___Hair loss
___Diarrhea
___Weight loss
___Increased sleeping
___Itchiness
___Weakness, glazed eyes
___Personality change
___Lameness
___Difficulty breathing
___Eye/nose discharge

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