



**Tri Lake Animal Hospital
& Referral Centre**

Patient Sticker

Reptile History Form

Date:

General History

Patient Name			
Common/scientific name			
Date of birth/Age		<input type="checkbox"/> Approximate	<input type="checkbox"/> Exact
Sex	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown <input type="checkbox"/> Neutered/Spayed	Determined by:	
		<input type="checkbox"/> Physical exam / Visual	<input type="checkbox"/> Endoscopy
		<input type="checkbox"/> Other	
Identification (please give number if applicable)	<input type="checkbox"/> Tag	<input type="checkbox"/> Tattoo	
	<input type="checkbox"/> Microchip	<input type="checkbox"/> Other	
What is the origin of your pet?	<input type="checkbox"/> Breeder	<input type="checkbox"/> Swap meet	
	<input type="checkbox"/> Pet Store / Online retailer	<input type="checkbox"/> Rescue	
	<input type="checkbox"/> Wild caught import	<input type="checkbox"/> Unknown	
	<input type="checkbox"/> Captive bred	<input type="checkbox"/> Other	
How long have you had your pet?			
Do you have other reptiles at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	
When was the last reptile added to your collection?			
Do you have other non-reptile animals at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	
Any contact with other reptiles in the last 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	

Diet

Please indicate which foods are eaten, and in what amounts (by number, weight, approximate volume, etc.):	
Plant material:	<input type="checkbox"/> Vegetables: Type and amount per feed: _____ <input type="checkbox"/> Frozen/thawed <input type="checkbox"/> Fresh <input type="checkbox"/> Other <input type="checkbox"/> Flowers: Type and amount per feed: _____ <input type="checkbox"/> Frozen/thawed <input type="checkbox"/> Fresh <input type="checkbox"/> Other <input type="checkbox"/> Fruits: Type and amount per feed: _____ - _____ <input type="checkbox"/> Frozen/thawed <input type="checkbox"/> Fresh <input type="checkbox"/> Other
Insects:	<input type="checkbox"/> Crickets (_____) <input type="checkbox"/> Locusts (_____) <input type="checkbox"/> Mealworms (_____) <input type="checkbox"/> Waxworms (_____) <input type="checkbox"/> Earthworms (_____) <input type="checkbox"/> Roaches (_____) <input type="checkbox"/> Other(_____)
Rodents/Other:	<input type="checkbox"/> Mice: Type and number per feed: _____ <input type="checkbox"/> Rats: Type and number per feed: _____ <input type="checkbox"/> Birds or fish: Type and number per feed: _____ <input type="checkbox"/> Freshly killed <input type="checkbox"/> Frozen/thawed <input type="checkbox"/> Live prey

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Reptile History Form (continued)

Do you feed any wild animals to your pet?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:
Any other food items fed? Describe	
How often do you feed your pet?	
When was food last offered?	
Does your pet eat consistently? Please describe.	
Any nutritional supplements offered?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:
Any recent diet changes?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:
What water supply do you provide?	<input type="checkbox"/> Tap water <input type="checkbox"/> Bottled water <input type="checkbox"/> Rain/river water
How is water provided?	<input type="checkbox"/> Bowl <input type="checkbox"/> Dripper system <input type="checkbox"/> Spray, how often:
How often is water changed?	
Do you use any water supplements?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:
Any changes in feeding or drinking behavior?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:
Any changes on droppings (fecal material, urine, or urates)?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:

Housing

Is your pet kept...	<input type="checkbox"/> Indoors	<input type="checkbox"/> Outdoors	<input type="checkbox"/> Both
What type of habitat/cage is used?	<input type="checkbox"/> Arboreal (tall, climbing)	<input type="checkbox"/> Terrestrial (primarily ground)	<input type="checkbox"/> Aquatic or Semiaquatic
What is the cage made of?	<input type="checkbox"/> Plastic / Fiberglass	<input type="checkbox"/> Wood	<input type="checkbox"/> Metal
		<input type="checkbox"/> Glass	<input type="checkbox"/> Mesh
			<input type="checkbox"/> Other
What décor and/or furnishings are present?			
Is there additional ventilation (mesh, fans)?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		
Does your pet have access to direct sunlight (not through glass or plastic)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Frequency and length of time:		
Does your pet have access to artificial full-spectrum (UVA and UVB) light?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Type and Brand of bulb: Length of time of light per day: How often the bulb is changed:		
What type of heating equipment is used?	<input type="checkbox"/> Ceramic or Infrared bulb Thermostat control? <input type="checkbox"/> Yes <input type="checkbox"/> No Power = ___W	<input type="checkbox"/> Spot light/bulb Thermostat control? <input type="checkbox"/> Yes <input type="checkbox"/> No Power = ___W	<input type="checkbox"/> Heat mat Thermostat control? <input type="checkbox"/> Yes <input type="checkbox"/> No Size= _____ <input type="checkbox"/> Outside or <input type="checkbox"/> Inside of cage
			<input type="checkbox"/> Aquarium water heater Thermostat control? <input type="checkbox"/> Yes <input type="checkbox"/> No Power = ___W
Any other heating equipment used?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		
Can the pet(s) touch or access the heat source(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		
Do you have meters that measure the following...?	<input type="checkbox"/> Temperature	<input type="checkbox"/> Humidity	<input type="checkbox"/> UVA/UVB
			<input type="checkbox"/> No meter present

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Reptile History Form (continued)

Is any additional lighting provided inside the cage?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of bulb? <input type="checkbox"/> Light bulb (Model and manufacturer: _____) <input type="checkbox"/> Fluorescent strip light (Model and manufacturer _____)		
When were the light sources last replaced?			
Are the light sources screened from the pet(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		
Can the pet(s) touch or access the light source(s)?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		
Does your pet have a gradient of temperatures?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Describe:	
What are the day time temperatures?	Hottest/Basking area: _____	Coolest area: _____	
What are the night time temperatures?	Hottest/Basking area: _____	Coolest area: _____	
Are these temperatures measured with a thermometer?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
How many hours of light/darkness does your pet have each day?	Light: _____ hours Dark: _____ hours		
Do you measure humidity in the enclosure?	<input type="checkbox"/> No <input type="checkbox"/> Yes (What is the humidity source and level? _____)		
Is your pet housed alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	
Any water available for in the enclosure for soaking?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:	
How often is the cage cleaned?			
What products are used to clean it?			
Are bathing facilities provided?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		
Does anyone in the household smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use any aerosolized products?	<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:		

Medical History

Has your pet ever been to another veterinarian?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Location and dates:
Any reproductive history?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Describe:
When did your pet last shed?		
How often does your pet usually shed?		
Does your pet have any history of any medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Describe:
Has your pet received any medications or treatments in the past 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Describe:
Have you noticed any changes in your pets behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Describe:
Have you noticed any changes in your pets defecation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Describe:

Reason For Today's Visit:

What is your reason for visit?	<input type="checkbox"/> Wellness / Healthy pet	<input type="checkbox"/> Sickness / Ailment / Injury	<input type="checkbox"/> Other
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Reptile History Form (continued)

If your pet is sick, what is the primary complaint today, or what signs have you noticed?		
How long have these problems been present?		
Have there been any changes in your pets environment in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Have any other animals or persons in the household had any illness in the last 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: