Tri Lake Animal Hospital & Referral Centre

Small Mammal History

Please take a moment to tell us about your pet

DATE: _____

CLIENT NAME: _____ **PET NAME**: _____

SPECIES: _____ **DATE OF BIRTH**: _____ ◯ Actual ◯ Estimate

SEX: ◯ Female ◯ Male ◯ Unknown ALTERED: ◯ Spayed ◯ Neutered ◯ Unknown

How long have you had your pet? _____ Where did you obtain your pet?_____

ENVIRONMENT:

Dimensions of cage: Height: _____ x Length _____ x Width _____ or Gallons: _____

Type of bedding/substrate: _____

Where in the house is the cage located? _____

How often is the cage cleaned? _____

Please describe cage accessories/toys: _____

_____

Does your pet have a cage mate? ◯ Yes ◯ No Species of cage mate: _____ Age of cage mate:_____

Sex of cage mate: ◯ Female ◯ Male ◯ Unknown Altered?: ◯ Spayed ◯ Neutered ◯ Unknown

Other pets in home: _____ Are they exposed to this pet? ◯ Yes ◯ No

Chinchillas: How often does your pet have a dust bath? _____

HANDLING:

How often is your pet handled? _____ For how long? _____

Does your pet spend time outside its cage? ◯ Yes ◯ No

Is your pet supervised outside its cage? ◯ Yes ◯ No ◯ Usually

Any other pertinent information: _____

_____

_____

TURN OVER FOR PAGE 2

NUTRITION:

What kind of food and treats are offered? _____

List everything your pet eats: _____

_____

List vitamin/mineral supplements including brand name: _____

MEDICAL HISTORY:

Purpose of Visit: _____

Please list previous/current medical problems: _____

_____

Please list current treatments: _____

_____

Appetite: ○ Normal ○ Increased ○ Decreased ○ Anorexic

Water Consumption: ○ Normal ○ Increased ○ Decreased ○ Not drinking

Describe: (Duration/Progression/Severity): _____

Stools: Colour _____ Consistency _____ Amount _____ Frequency _____

Urination: Colour _____ Amount _____ Frequency _____

Have you noticed any of the following? (*tick all that apply)*

Weight Loss	**Weight Gain**	**Vomiting**	**Sneezing**	**Abnormal Stool**
Decreased Urination	**Difficulty Urinating**	**Difficulty Breathing**	**Coughing**	**Increased Urination**
Nasal Discharge	**Eye Discharge**	**Excessive Shedding**	**Hair Loss**	**Itching**
Skin Sores	**Lumps or Masses**	**Poor Posture**	**Head Tilt**	**Decreased Activity**
Loss of Balance	**Limping**	**Pain**	**Wounds**	**Lethargy**

Other: _____

Please describe the location or change: _____

Recent changes in behavior: _____

_____

Signature: _____ **Date**: _____