History Form – Avian & All Exotics – *Initial or Annual Exam*

North Central Animal Hospital

Date	Client name	Pet Name	Species	Acct. #
____________	________________________	______________	___________	_________

Initial Exam: Source: Pet store, Breeder, Show, Shelter, Stray, Other____________________ & date_________

Wild caught / Captive bred / Domestic parent raised / hand raised / other: ___________________________

Approximate age when obtained: ____________ Number of previous owners: _____________________

Any prior veterinary exam, or since last visit here? No Yes, Date: _____, Hospital Name: _______________

*Reason for that visit:*____ *Previous vaccines?*_________

Wings, nails & beak trimmed: No Yes Where:_________________ **How often:**_________________

Boarding: No Yes Where:________________ **How long:** __________ **How often:**_________________

Main Reason for Visit:____

____

How long have any problems been noted? ______________________________________

Medications: No Yes ____

Vitamin or mineral supplements: No Yes____

Body Weight: no change weight loss weight gain

Activity: normal increased decreased

Appetite: normal increased decreased **My pet last ate:**_________ (am / pm)

Drinking: normal increased decreased

Droppings (urine, stool, & urates): normal abnormal, ____

Vomiting/Regurgitation: No Yes ____

Sneezes/ Nasal discharge/Coughs: No Yes____

Breathing heavy/ Voice Change: No Yes, ____

Skin changes: No Yes ____

Scale Shed history: Date:___________ Select: Single piece Multiple pieces Frequency:_________

Fur problems: No Yes, ____

Feather changes: No Yes, ______________________________ Last molt:_____________________

Pain/Lameness: No Yes(mild moderate severe) Location: ___________________________

Weak/Falling: No Yes ____

Behavioral concerns: No Yes ____

Eggs laid: No Yes, (Dates, #, and frequency)____

Microchip: No Yes_____________________

Diet: (list brand name or type, amount fed, and amount pet eats)

Formulated Pellet: No Yes, Brand: _____________________________________, _____% of diet

Seeds/Nuts: No Yes____

Mixes/Home cooked diets(list all ingredients): No Yes____

Insects/Meats/Eggs: No Yes, Cooked Canned Raw _______________________________

Prey: No Yes, Live Dead thawed frozen _______________________________________

Hay: No Yes, Timothy orchard grass Bermuda Alfalfa other:_____________________

Vegetables: No Yes, ____

Fruits: No Yes, ____

List other foods: bread, rice, pasta, potatoes, dairy products, candy, snack foods, other:_________________

Source of drinking water: Faucet R/O filtered other____________________________

Frequency food is changed:_____________________ Frequency water is changed:____________________

Soak/Bathe: No Yes Frequency:__________________ Time: _________ Method:____________________

Cage: Size: _______________ Structure material: _________________ Location: _____________________

Type of bedding:_____________________ Frequency bedding is changed:_________________________

Enclosure temperature range: ____to ______ F Humidity ranges from ______ to ______

Heat sources include: house HVAC Basking light Heat lamp Heatrock Heating pad under tank

UV light sources include: UVA UVB Vitalight Blacklight direct sun (no window)

Disinfectants used to clean enclosure: __________________________________How often?___________

Any other pets in household: No Yes, Same cage? No Yes Are any ill? No Yes____

Type & number:____

When was the most recent addition? ____

Exercise: Method:____ Frequency :_________________________

Time outside of cage: _______, Frequency: _________, Supervised: No Yes Roams house: No Yes

Outdoors: Never 50% always other ____________

How often handled?_________________________ By whom?(if children please list ages) ___________________

Any humans in household sick? No Yes Anyone immune compromised/young/elderly? No Yes

Please email completed form to: NorthCentralReceptionists@gmail.com