ROUTINE EXOTIC HISTORY

Pet: _____ Owner: _____ Date: _____

Today's Weight: _____ Today's Temp: _____ Photo taken _____

Chief Complaint or Reason for Visit: [] Routine Vaccinations

[] Other _____

Has your pet been seen for **same condition** recently? [] Yes [] No (When: _____)

Vaccinations up to date?   [] Yes [] No

Spayed / Neutered?   [] Yes [] No

Heartworm preventive used?   [] Yes [] No (What kind? _____)

Flea control used?   [ ] None [] Frontine® [] Advantage/Advantix® [] Other: _____

Have you ever seen fleas or ticks on your pet?   [] Yes [] No

Are mosquitoes or biting flies a problem in your area? [] Yes [] No

How often do you bathe your pet? _____ What shampoo used? _____

Does your pet swim?   [] Yes [] No If yes, how often?_____

Any **worms** seen?   [] Yes [] No (Describe: _____)

Any **injury or illness** in past 30 days?   [] Yes [] No (Describe: _____)

On any **medications/supplements**?   [] Yes [] No (Describe: _____)

Has your pet ever had any **adverse reaction** after vaccinations or drugs/medications: [] Yes   [] No

(Describe: _____)

Time **outdoors**?   []Daily for bathroom/walks []50:50 Indoor/outdoor []Outdoor only

Does your pet: Board   Groom   Dog parks   Obedience/training class   Neighborhood dogs   Travel with you

Other pets in the house? _____

Are your other pets vaccinated and on heartworm and flea and tick preventative, if applicable? [] Yes   [] No

Diet: _____ How many times / day do you feed your pet? _____

Table scraps?   [ ] Yes [ ] No

Appetite: [] Increased   [] Normal   [] Decreased

Water Consumption?   [] Increased   [] Normal   [] Decreased

Weight: [] Gain   [] Stable   [] Loss

Bowel Movements?   [] Normal   [] Constipated   [] Diarrhea   [] Bloody

Urination?   [] Normal   [] Increased   [] Decreased   [] Bloody

Vomiting?   [] Yes [] No

Coughing or sneezing   [] Yes [] No

Any Listlessness?   [] Yes [] No

Any Seizures?   [] Yes [] No

Shaking Head?   [] Yes [] No

Scratching/Scooting?   [] Yes [] No

Significant Hair Loss? [] Yes [] No   [] Patchy [] Generalized [] Excessive Shedding

Unusual Lumps or Bumps? [] Yes [] No   (Location: _____)

Bad Breath?   [] Yes [] No

Unusual Discharge?   [] Yes [] No   (Location: _____)

Lameness?   [] Yes [] No   (Which Leg? [] RF [] LF [] RR [] LR)

Stiffness or Difficulty Rising? [] Yes [] No   After sleeping? [] Yes [] No   After exercise? [] Yes [] No

Any Behavioral Changes? [] Yes [] No   (Describe: _____)

Anything else we need to know?