



## Exotic Mammal History

Owner's Name:	Date:
Patient's Name:	Species:
Length of ownership:	
From what source did you acquire it? <input type="checkbox"/> Pet Shop <input type="checkbox"/> Breeder <input type="checkbox"/> Other:	
Does your pet eat everything offered? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Food type (be specific):	
Supplements (be specific):	
Enclosure Type:	Temperature:
Substrate: <input type="checkbox"/> Newspaper <input type="checkbox"/> Artificial Turf <input type="checkbox"/> Wood Chips <input type="checkbox"/> Stones <input type="checkbox"/> Coconut <input type="checkbox"/> Other:	
Is your pet allowed out of its cage for exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you noticed any current health problems? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain: If yes, how long have you noticed them?	
Any previous illness? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:	
Any recent medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list:	
When did your pet last eat?	
Any change in appetite? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Any change in color or consistency of droppings? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Any regurgitation? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Any respiratory problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Any other animals in the enclosure? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, do those animals have similar symptoms: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Any new animals in your collection? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where are they from:	
Has this pet been exposed to any other animals? <input type="checkbox"/> No <input type="checkbox"/> Yes	
For ferrets, please note any vaccines (and dates last given) that your pet has had:	
Other Comments:	