

Patient History - Reptile

Office use
DR <input type="checkbox"/> IN <input type="checkbox"/>
RM

DATE _____

Owner's Name: _____ Pet Name: _____

Species: _____ Date of Birth/Age: _____

Source of Pet/Date Acquired: _____ Sex: M F Unknown

Color: _____ Identification/Markings: _____

Enclosure:

Habitat/Enclosure (Size, Type, Covering/Lid): _____

Bedding/Substrate: _____ Hide Box/Shelter (Type): _____

Climbing Items/Accessories: _____

Water Bowl/Size/How often cleaned: _____

Heat Source: _____ Light Source: _____

UV Source(Brand): _____ Changed every _____ months

Temperature: Warm end _____ Cool end _____ Average Humidity _____

Enclosure: Cleaned how often and with what?: _____

Environment:

Is the pet allowed out of the cage? If so, under what conditions? _____

Are there any other pets in the household? List species and how many of each: _____

Is your pet in any contact with other pets/animals? _____ If Yes, please list: _____

Is your pet kept indoors or outdoors (or both)? _____

Is your pet exposed to extreme temperature fluctuations/drafts? _____

Does anyone SMOKE in the house? _____

Recent environmental changes: _____

Diet:

Offered food type/size: _____ Date of last meal: _____

Is food offered fresh-frozen, fresh-killed, or live prey? _____

Is food offered in main enclosure? _____

Food consumed/Offered how often: _____

Dietary supplements offered? List: _____

Previous History:

History of laying eggs/reproducing? When was last time? _____

How often does pet normally shed? When was last shed: _____

History of internal/external parasites? _____ If yes, last time and treatment? _____

Has the pet been seen by a veterinarian before? Is so, whom? _____

The reason for your visit today/Health concerns about your reptile: _____

***** OFFICE USE *****

Wt. _____ g/kg

Today's Plan: Nail Trim Fecal Mite Check Blood Work Picture DONE _____

Notes: _____
