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?