



SMALL MAMMAL HISTORY FORM

Pet's Name: _____ Client: _____ Date: _____

Species: **Guinea Pig / Chinchilla / Degu / Hamster / Gerbil / Rat / Mouse /
Sugar Glider / Hedgehog / Other** _____

Sex: **M – F - Unsure**

Neutered: **Yes – No - Unsure**

Is this your first small mammal? **Yes - No** First of this type? **Yes - No**

Date of birth _____ (Circle): **actual - estimate**

When did you get your pet? _____

Source: **Pet Store / Pet Show / Breeder / Private Party / Shelter / Other** _____

Environment

Approximate cage dimensions: H _____ x W _____ x L _____ or Gallons: _____

Substrate (Circle): **Care Fresh / Yesterday's News / Wood Shavings (cedar – pine)**

Hardwood Chips (aspen – walnut) / Newspaper / Other _____

How often is the cage cleaned? _____

Cage Accessories: **Sleeping Box - House / Climbing Toys / Shelves - Levels**

Cage Toys: **Exercise Wheel / Play Tubes / Chew Toys / Other** _____

Is cage shared with another animal? **Yes – No** Species of cage mate: _____

Sex of cage mate: **M – F – Unsure** Neutered? **Yes – No - Unsure**

Other Pets in the Home: _____

Are they exposed to this pet? **Y – N** In what way? _____

How much time does your pet get out of its cage per day? _____ minutes

Is your pet supervised when it is outside of its cage? **Yes (always) – Usually - No**

Nutrition

Diet (detail everything offered) _____

List everything your pet eats: _____

Vitamin & Mineral Supplements: _____

Name _____

Medical History

List current medical problems / Primary Complaint: _____

Current treatments or supplements: _____

Please list any previous medical problems (dates & treatment)

Current Appetite: **Normal – Increased – Decreased – Anorexic**

Describe (duration, progression, severity): _____

Stools: **Color** _____ **Consistency** _____ **Amount** _____ **Frequency** _____

Urination: **Color** _____ **Frequency** _____ **Amount** _____

Have you noticed (Circle all that apply):

weight loss, weight gain, masses or lumps (where _____)

abnormal urination, abnormal stools, vomiting, other discharge _____

difficult breathing, coughing, sneezing, nasal discharge _____

excessive shedding, hair loss, itching, skin sores (where _____)

poor posture, head tilt, loss of balance, limping (which leg _____)

lethargy, inactivity, pain (where _____)

Describe other changes: _____

Previous Veterinary Visits: **Yes – No**

Date of last visit _____

Doctor _____

Clinic _____

Phone _____

Records requested? **Y – N** Received? **Y – N**

Previous Lab Tests / Diagnostics: **Y – N**

Date of Last Testing _____

Complete Blood Count O Chemistry Profile O Fecal Exam O Urinalysis O

Bacterial Culture O Radiograph (X-ray) O Other Tests _____

Results Requested? **Y – N** Received by Clinic? **Y - N**