

**FOUR CORNERS VETERINARY HOSPITAL
SMALL MAMMAL HISTORY FORM**

Owner's Name: _____ Pet's Name _____ Date: _____

1. Patient information

Species: _____ Sex: male female unknown. spayed/neutered
Date of birth (if known) or estimated age _____ Date acquired or how long owned _____
Source: pet store pet was born at my home breeder previous owner found as stray
other _____
Is there a microchip in this pet? Yes No

2. Diet

What percent of your pet's diet consists of the following (please describe what the pet actually eats).
The total should add to 100%:
Hay ____% Timothy Alfalfa Won't eat hay other: _____
Pellets ____, Timothy based Alfalfa based Lab blocks Don't know type
Brand: _____ Do the pellets have grain, corn, seeds, treats mixed in? yes no
Fruit/vegetables ____, types: _____
People food ____, types: _____
Grazing in yard ____% Daily 1-3 times per week less than once per week
Other ____, types: _____
Treats: types, frequency: _____
Supplements: _____ Is it put in the drinking water or given directly to the pet?
Water source: bowl sipper bottle
Please describe any recent additions/changes to your pet's diet _____

3. Environment

Is your pet kept indoor only indoor and outdoor outdoors only
How big is the cage? _____
Cage walls are made of wire wood glass plastic other: _____
Cage floor is made of wire wood glass plastic other: _____
Bedding: none paper/newspaper/Care Fresh/Yesterday's news
pine/aspens/cedar shavings towels/cloth other: _____
Are there are other pets in the same cage? yes no. If so, how many _____
List any other pets that you have _____
How much time does your pet spend outside of the cage? _____
Is your pet supervised when it is out of the cage? at all times sometimes no
How often is the cage cleaned _____ What products are used? _____
List recent changes in the environment, if any: _____

→ → → PLEASE COMPLETE THE OTHER SIDE OF THIS FORM → → →

4. Medical History

Has your pet ever had tooth trimming or tooth problems? yes no not sure

Do you plan on breeding this pet? yes no possibly. How many litters has he/she had? _____

Previous Illness, Problems, Surgeries (list with date, if known)_____

Has your pet been seen by another veterinarian? yes no If yes:

When was the most recent visit?_____ May we contact this hospital for records? yes no

5. Is your pet here for a: healthy pet check up, or is there a problem?

If your pet is sick, please describe the signs and how long the pet has been showing these signs:_____

Is your pet eating normally? yes less than normal not at all

Are the droppings: normal decreased in size or number softer than normal/diarrhea

Have you noticed any of the following:

- Weight loss Weight gain
- Discharge from the eyes or nose
- Sneezing
- Increased breathing rate or effort
- Vomiting
- Abnormal skin/fur Itching
- Weakness Limping

Have you used any medications? no yes (list):_____

6. Is there anything else you would like done today?

Nail trim Other_____

I have questions about: _____