

# SMALL MAMMAL PRE-EXAMINATION HISTORY CHECKLIST

Please complete the information below so we can keep our records up to date

Owner's Full Name: \_\_\_\_\_ Date: \_\_\_\_\_ Pet's Name: \_\_\_\_\_ Pet's Age: \_\_\_\_\_

Street Address, City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

What do you feed your pet? \_\_\_\_\_

How Much? \_\_\_\_\_ How Often? \_\_\_\_\_ Nutritional Supplements? \_\_\_\_\_

Has your pet eaten today? Y / N \_\_\_\_\_ What? \_\_\_\_\_ What Time? \_\_\_\_\_

Does your pet have any allergies or vaccine reactions? Yes No \_\_\_\_\_ To What? \_\_\_\_\_

Do you use any flea/tick preventative? Y / N What kind? \_\_\_\_\_ Date last administered? \_\_\_\_\_

Does your pet go outside? \_\_\_\_\_

Type of caging and bedding used? \_\_\_\_\_

Where is the cage kept? \_\_\_\_\_

## HAS YOUR PET SHOWN ANY OF THE FOLLOWING SYMPTOMS:

Weight gain \_\_\_ Weight Loss \_\_\_ NO Description \_\_\_\_\_

Appetite increase \_\_\_ Decrease \_\_\_ NO Description \_\_\_\_\_

Diarrhea \_\_\_ NO Description \_\_\_\_\_

Constipation/Difficult Defecation \_\_\_ NO Description \_\_\_\_\_

Increased Drinking \_\_\_ Increased Urination \_\_\_ NO Description \_\_\_\_\_

House Soiling: incontinence (dribbling urine) \_\_\_ Stool \_\_\_ NO Description \_\_\_\_\_

Bad Breath \_\_\_ Drooling \_\_\_ Difficulty Chewing \_\_\_ NO Description \_\_\_\_\_

Coughing \_\_\_ Sneezing \_\_\_ Wheezing \_\_\_ NO Description \_\_\_\_\_

Trouble Eating \_\_\_ NO Description \_\_\_\_\_

Uncoordinated \_\_\_ NO Description \_\_\_\_\_

Lameness \_\_\_ Stiffness \_\_\_ Decreased Activity \_\_\_ NO Description \_\_\_\_\_

Listlessness \_\_\_ Weakness \_\_\_ NO Description \_\_\_\_\_

Muscle Tremors \_\_\_ Shaking \_\_\_ Seizures \_\_\_ NO Description \_\_\_\_\_

Unusual discharges \_\_\_ Body Odors \_\_\_ NO Description \_\_\_\_\_

Scotting of the rear end \_\_\_ NO Description \_\_\_\_\_

Head Tilts \_\_\_ Ear Scratching/rubbing \_\_\_ NO Description \_\_\_\_\_

Increase of Grooming\_\_\_ Decrease of Grooming \_\_\_

NO Description \_\_\_\_\_

Itching\_\_\_ Scratching\_\_\_

NO Description \_\_\_\_\_

Poor Coat \_\_\_ Hair Loss \_\_\_

NO Description \_\_\_\_\_

Change in Behavior \_\_\_

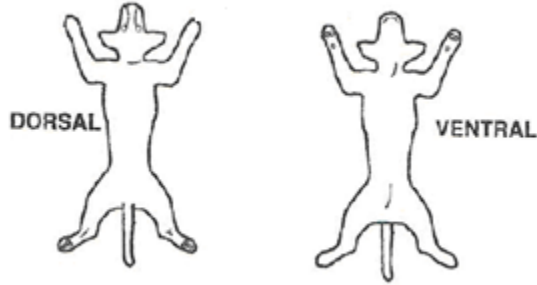
NO Description \_\_\_\_\_

Skin problems (Please note location on diagrams below)

NO Description \_\_\_\_\_

Lumps or bumps

NO Description \_\_\_\_\_



ANY OTHER PROBLEMS OR CONCERNS?

NO Description \_\_\_\_\_

I Hereby authorize SUFFIELD VETERINARY HOSPITAL to preform professional services as are in their opinion necessary and advisable for treatment and maintenance of my pet's health and wellbeing. I also authorize SUFFIELD VETERINIARY HOSPITAL to perform the following, if deemed necessary:

Bloodwork: \_\_\_(please initial) X-rays: \_\_\_(Please Initial) Sedation: \_\_\_ (Please Initial)

I Understand professional service are to be paid at the time they delivered.

I will satisfy payment by the following method:

\_\_\_Cash \_\_\_Check \_\_\_Master/Visa/Discover/AMEX

The number where I can be reached today is: \_\_\_\_\_

**I am the owner or agent of the aforementioned animal, am at least 18 years of age, and am competent to contract in my own name. I have read this document in its entirety before signing below and I fully understand all of the content in this document and its meaning. I fully understand the impact of signing this release.**

SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

[STAFF-Reception: Account Number:\_\_\_\_\_ Receptionist Initials:\_\_\_][Staff-Tech: Admitting Technician Initials:\_\_\_]