

ALL Creatures Family Pet Hospital

Exotic Pet Questionnaire: Rodent



Client Name: _____ Date: _____

Patient Name: _____ Breed: _____

Gender (Circle one): Female Female/spayed Male Male/neutered

1. What is the reason for bringing your pet(s) to ALL Creatures Family Pet Hospital for examination? (Example: annual wellness, eye problem, losing weight...etc.)

Has your pet been previously examined by a veterinarian at a different veterinary hospital? YES/NO (circle one)

If YES, please provide copies of medical records, if available.

2. How did you acquire your pet (i.e. from where or whom?)

3. When was your pet born? _____

4. How long have you been providing care for your pet? _____

5. **What do you feed , how much and how often** do you feed your pet?

(Examples: ¼ cup of fresh vegetables, daily rat block, hamster food from Publix...etc.) _____

6. Any changes in your pet's appetite? _____

7. **Do you add** vitamin or mineral supplements to your pet's diet? YES NO

(Circle one) If YES, **how often, how much and which brands** do you use?

*Please, **bring all supplements with you to your first appointment** for evaluation.

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8. Do you house your pet indoors or outdoors or both? (Circle one)

9. What type of habitat do you provide for your pet and what are the approximate dimensions? _____

10. Describe exercise activities and frequency of activities:

11. Has your pet's level of activity changed and, if so, how?

12. Do you allow your pet to roam freely throughout the house or in areas outside of its habitat? YES NO (Circle one) If YES, please elaborate: _____

13. What type of **substrate** do you place in the housing area? (Example: newspaper, towels, wood chips, compressed paper, CareFresh, none...etc.)

How often do you change the bedding/substrate? _____

14. How frequently do you provide fresh **water** for your pet & how do you provide it? (Example; water bottle or bowl) _____

15. Any changes in your pet's water consumption? _____

16. Any changes in your pet's urine output or characteristics? (Example: different color, strong odor, bloody...etc.) _____

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17. What is the ambient temperature of your pet's habitat? _____ °F
18. How many pets do you house in the same **enclosure**? _____
19. Have you noticed any changes in your pet's fur? _____

20. How often does your pet **defecate**? _____
21. Any changes in the appearance, frequency, or odor of your pet's feces? If so, please describe the problem (Example: diarrhea, constipation...etc.) _____
_____ And
for how long? _____
22. Is your pet **currently receiving any prescription or over the counter medications**? YES NO (circle one) If yes, what medication(s) are you administering, at what dose and frequency and how long has your pet been receiving the medication(s)? _____

23. Have you in the past or are you currently using any flea control products on your pet? YES/NO (circle one) IF YES, which product(s), what dose did you administer, how often and when was last use? _____

24. What other types of animals live in the same **household** with your pet?

25. If your pet is a female, has she previously or recently given birth? YES/NO (Circle one) If yes provide date(s), number of babies and if any complications occurred: _____

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If you have observed any of the following with your pet, please circle:
DROOLING, DROPPING FOOD, SWELLING ON SIDE OF FACE,
SWELLING ON BOTTOM OF JAW, HEAD TILTING TO ONE SIDE,
WOBBLY GAIT FALLING OVER, BREATHING FASTER THAN NORMAL,
HAIR LOSS, SWOLLEN ABDOMEN, DIARRHEA, DECREASED OR LACK OF
FECAL OUTPUT, STRAINING TO URINATE OR DEFECATE, BLOOD IN
URINE OR FECES, SLEEPING MORE THAN USUAL, WEAKNESS,
LETHARGY

Please, provide any additional pertinent information you feel is important,
regarding the care of your pet and it's health, not covered in this questionnaire:
