# 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?**