Reptile Information Sheet

Please fill out this form completely and bring with you to your appointment so that we can use the information to provide the best care possible for your pet.

Contact Information

Owner's First Name: ____________________ Owner's Last Name: ________________________________

Patient's Name: ___________________ Species: ____________________ Age: _______________

Sex: Male / Female / Unknown How was sex determined: ___________________________________

Length of ownership: ___________________________ Quarantine period: __________________________

Where did you obtain pet? ____

Housing/Environment

Size and type of cage: ____

How often is cage cleaned? ______________ What cleaner(s) do you use? ___________________________

Where is the cage located within your home? ____

Temperatures: Cool ____ Warm _____ Basking ____ How are they measured? ____________________

What types of heat source are you using? ____

What is the cage's humidity? _______ How is it measured? ______________________________________

What do you use for a light source? ____

Do you have a broad spectrum (UVB/UVA) bulb? Yes / No How often is it changed? _________________

Light cycle: Manual / Timer Duration: Hours of light _________ Hours of dark _________

Substrate (material on the bottom of the cage): ____

What objects are in the cage? ____

How often do you soak ? _______________ When was the last soak? _______________________________

Does your pet spend time outside of enclosure? Yes / No Is it supervised? Yes / No

Any other reptiles in the house? Yes / No

List types and how long you have had them and where they are in relation to this pet: ____

Other pets: ____

Any changes in the past 6 months: Move / Cage Change / Travel / Loss of People or Pets

Has your pet left the house in the past year? Yes / No If so, where? ______________________________

Any contact with reptiles outside the home? Yes / No Describe: ___________________________________

Diet

Please describe your pet's diet. (Include types, amounts, frequency, live vs killed prey items, etc.)

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Do you offer any supplements, vitamins or water additives? Yes / No

Type, amount & frequency of administration:____

Last time you fed? ________________________ Last time your pet ate? ____________________________

History

Frequency of shed: __________________________ Last shed? ____________________________________

Any issues with shedding? Yes / No Describe: ____

Has your pet been examined by another vet? Yes / No When? __________________________________

Any injuries, illnesses or surgeries? Yes / No Describe: ____

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Have any been seasonal? ____

Currently on any medications? Yes / No List:

____

Any adverse reactions to any medications? Yes / No Describe: ____________________________________

Have you noticed any of the following clinical signs at home? (please circle any applicable)

Cough Sneeze Runny Nose Runny Eyes Behavioral Change

Change in Appetite or Thirst Vomiting/Regurgitation

Other: ____

Please share any additional concerns or information you feel is pertinent to your pet's care:

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