



Capri Plaza Pet Clinic - Rabbit Exam Questions

REASON FOR TODAY'S VISIT

If for illness or injury, please include date first noticed, changes observed during the problem, methods of treatment used (if any), and any other important, pertinent details.

Has your pet been (having):

Polyphagia (Eating more)

Anorexia (Eating less)

Coprophagy (Eating droppings)

Polydipsia (Drinking more)

Drinking less

Increased salivation

Dropping food from mouth

Odor noticed from mouth

Abnormal bowel movements

____ Soft ____ Hard ____ Small ____ Large ____ Liquid ____ None

Change in color or appearance of feces

Change in odor of feces

Weak ^

Polyuria (Having larger urine puddles)

Uncoordinated ^

Change in urine color

Abnormal posture ^

Straining (to urinate or defecate)

Known external wounds, bleeding ^

Sneezing

Active/playing ^

Nasal discharge

Chewing less ^

Wheezing

Chewing more ^

Labored breathing

Aggressive behavior ^

Sleepy

Hiding more ^

Gender: Male Female

Neutered or spayed? _____ **If yes, when?** _____ **At what age?** _____

How old is your pet? _____ **Length of time in household** _____

Where did you obtain your pet from?

Pet Store (which one?) Breeder Private party Rescue group Found Gift Other

How many guinea pigs are in the household? _____

How many guinea pigs are in the same enclosure? _____ **Do they get along?** _____

Other pets? _____

Children in the household? _____ **Is your pet vaccinated for Rabbit Hemorrhagic Disease?** _____

Females only: How many litters? _____ **When was last litter?** _____

HOUSING

Does pet have access to: Entire house Yard Fenced area Exercise wheel?

Other special quarters (such as aquarium)? _____

How often do you clean cage? _____

Size: _____ x _____ x _____

Temperature in enclosure: Day? _____ **Night?** _____

Duration of light: _____ hrs **Dark:** _____ hrs

Hours in direct sunlight? _____

Hours in direct sunlight? _____

Lights turned on/off by family? _____

DIET / FEEDING

Pet's diet: Seeds _____ % **Pelleted diet** _____ % **Brand?** _____

Hay _____ % **Fresh produce** _____ % **Types?** _____ **How often?** _____

Table foods _____ % **Types?** _____ **How often?** _____

HISTORY:

Please list briefly any previous health problems, including when they were noticed and when and how they were resolved:

Adverse reactions to medications?

Date of last medical examination ^ Results:

Date of last fecal parasite test ^ Results: Neg^ Positive (what kind?)