

Madison Veterinary Hospital, P.A.

262 Main Street, Madison, NJ 07940

AVIAN HISTORY FORM

Date:_____

Client Name:_____ Patient Name:_____

Breed:_____ Birthdate:_____

Please complete as much as possible of this history sheet and bring it to the hospital on the day your pet is scheduled to have its examination.

Preferred Doctor to do Examination:_____

Check All That Apply.

Diet

Seeds Type:_____ Pellets Type:_____

Vegetables Type:_____

Fruit Type:_____

Vitamin/Mineral Supplement Type:_____

Other Type:_____

Environment

Type of cage:_____

Location:_____

Number of species in cage:_____

Number of pets in same cage:_____

Temperature: Day_____ Night_____

Physical Symptoms

Vomiting Frequency?_____ Vomits what?_____

Diarrhea Frequency?_____ Color?_____

Consistency?_____ Blood?_____

Appetite: Decreased Increased No Change

Thirst: Decreased Increased No Change

Breathing: Normal Abnormal Abnormality:_____

Coughing: No Yes Frequency/Consistency:_____

Sneezing: No Yes Frequency/Consistency:_____

Droppings: Normal Increased Decreased

Problems with droppings:_____

Activity: Normal Decreased Increased How?_____

Last molt_____

Appearance

Feathers/Skin: Normal Abnormal How?_____

Weight: Normal Increase Decrease How much?_____

Eyes: Normal Abnormal How?_____

Other Symptoms: Please list any questions or concerns.

Medications: Please list any current or past medications.

Thank you for completing this health questionnaire. Your answers are very important in focusing our attention on the areas in which your pet might need help.