EXOTICS History Form

Client Name: _____ **Patient Name:** _____

Date: _____

Current illnesses: _____

Current Medications: _____

Diet: _____

How much: _____ How often: _____

Vitamins: _____ Treats: _____

Water: ☐ bottle ☐ bowl Water changed (*times/day*) _____

Housing: ☐ outdoors ☐ indoors *(location inside)* _____

Enclosure made of _____

Dimensions: _____ Bedding Used: _____

Other: _____

_____

Exercise: _____

Lighting: _____

Location relative to pet: _____

How many hours daily: _____ How often bulbs changed: _____

Time spent outside: _____

Temperature: day _____ night _____

Basking area? _____ Heat source: _____

Humidity: _____% Mist/soak? _____

Other: _____

_____