



### Small Mammal/Rodent Information

Owner's Last Name \_\_\_\_\_ First \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ Age/Birthday \_\_\_\_\_

Species \_\_\_\_\_ Breed \_\_\_\_\_ Coloring \_\_\_\_\_

Sex: Male  Female  Spayed/Neutered? Yes  No  Microchipped? Yes  No

How long have you owned your pet? \_\_\_\_\_

Please list all foods and treats given:

Is their water source from a bottle  or bowl  How often changed? \_\_\_\_\_

What type of cage and bedding:

Is this pet caged with other pets? (please list)

List any medications or supplements given:

List any major surgeries, illnesses or medication reactions your pet has had:

Previous Medical Records? Yes  No

If yes, which clinic? \_\_\_\_\_ May we contact them? Yes  No

Does your pet have Pet Insurance? Yes  No  If yes, with whom? \_\_\_\_\_

Reason for exam:	Annual Physical	Masses or Lumps
Abnormal Behavior	Difficulty moving	Itching/Hair Loss
Diarrhea	Lethargy/Listlessness	Inappetance
Coughing/Sneezing	Eye/Nasal Discharge	
Other:	_____	

This form can be faxed to us at (509) 505-0251  
or scanned and emailed to [pinetreehospital@gmail.com](mailto:pinetreehospital@gmail.com)  
or brought in with you for your first appointment

**Professional Fees are to be paid at time of services.**

For your convenience we accept cash, check (with a valid driver's license), visa, mastercard, american express, discover and care credit. Returned checks are subject to a \$35.00 fee.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_