Grafton Animal Hospital Avian Wellness Health Questionnaire

To help us make the proper recommendation to you concerning your pet's health care needs please complete the following questionnaire.

Pet's name: _____ Species: _____ DOB: _____ Date: _____

A) Lifestyle Circle your best response**:**

1. **If you are new to our practice** do you have specific knowledge regarding previous care (illnesses, feedings, etc…)?

   Yes No N/A

2. Please list the name and city of your previous veterinary clinic: _____
3. I have the following number of pets: **Dogs-____; Cats-____; Birds- ____; Other: _____**

Please 4. My pet bird lives in a (please circle): **indoor cage 100% mostly indoor cage mostly outside cage**

- **a.** Please describe the bird's cage:
- **b.** Describe perches (number, size, and material): _____
- **c.** List anything else put in the cage (treats, toys, supplements, mite protector, etc..):
- **d.** Where is the cage located?
- **e.** Any windows near the cage? Y / N
- **f.** Any air conditioner or heating vents near the cage? Y / N
- **g.** What type of heating system is in your home? _____
- **h.** Do you have any humidifiers? Y / N
- **i.** How much time does the bird spend out of the cage? _____
- **j.** Is your bird supervised when outside of cage? Y / N

Circle 5. My bird is allowed out of cage to move around the house: (**unsupervised / supervised) never rarely frequently**

6. My pet bird is allowed to go outside (please circle): **never rarely frequently**
7. How long have you owned your bird? _____ From where? _____
8. My bird's sex is _____ . How was this determined? **DNA / Surgery**

   If your bird is a female, has she ever laid eggs? **Y / N** How often? _____

Y / N 9. I take my pet to **boarding grooming or pet stores** (please circle all that apply). When was last visit? _____

10. Grooming: Do you clip the bird's wings? Y / N Who clips the wings? **Yourself Pet Store Veterinarian**
    Do the nails require trimming? Y / N (If yes, how often? _____)
    Does the beak require trimming/filing? Y / N (If yes, how often? _____)
    Do you give the bird baths or showers? Y / N
    Do you ever apply anything other than water to the feathers or skin? Y / N

11. Diet- Please be specific (indicate what is actually eaten, not what is fed):

    Seeds= _____ % of diet eaten Brand: _____

    Pellets=_____ % of diet eaten Brand: _____

    Veggies= _____ % of diet eaten Type: _____

    Treats= _____ % of diet eaten Type: _____

    Meats: how often? _____what type? _____

    Fruits: how often? _____ what type? _____

    Bread, rice, potatoes, pasta: how often? _____what type? _____

    Other: Type _____ Frequency _____

12. Do you use a vitamin or mineral supplement? Y / N Type: _____
    Does it go in the water? Or, on the food? How often? _____ Amount: _____

(Continued on back)

B) Owners Observations: Have you noticed any of the following (Please circle the best answer)

Y / N 1. Weight changes?

Y / N 2. Changes in appetite?

Y / N 3. Drinking more or less than normal? ↑ ↓ **(Please circle one)**

Y / N 4. Stool droppings more or less than normal? ↑ ↓ **(Please circle one)**

Y / N 5. Lameness (limping) or Tenderness?

Y / N 6. Digestive upsets? (If yes, circle type: Vomiting, Diarrhea, Flatulence)

Y / N 7. Feather Changes?

Y / N 8. Eye discharges or changes?

Y / N 9. Sneezing, Coughing, or Drooling?

Y / N 10. Scratching, Rubbing, Self biting (biting at himself)?

Y / N 11. Ear Discharge, Head Shaking, or Ear Scratching?

Y / N 12. Bad breath or other odors?

Y / N 13. Changes in sleep patterns?

Y / N 14. Changes in exercise tolerance, agility, or ability to move around? **(If YES – continue to section C-a)**

Y / N 16. Behavior Changes or Issues? (If Yes, circle type: Excessive screaming, Destruction of property, Aggression/Fighting, Other: _____) **(If YES – continue to section C-b)**

Y / N 17. Do you have any other concerns you would like to discuss with the doctor today?

ALL SENIORS CONTINUE TO SECTION C

C) Seniors (Small Birds 7 years of age and older, Large birds 20-30 years and older)

a) Changes in exercise tolerance, agility, or ability to move around

Y / N 1. Falls off perch?

Y / N 2. Has difficulty rising, sitting, or squatting to eliminate?

Y / N 3. Prefers lying to standing?

Y / N 4. Holds up a particular foot when at rest? (please circle one) (Left foot or Right foot?)

Y / N 5. Has an obvious limp? (please circle one) (Left foot or Right foot?)

Y / N 6. Can't fly?

Y / N 7. Has an obvious wing droop? (please circle one) (Left wing or Right wing?)

b) Behavior Changes

Y / N 1. Disorientation (circle): stares into space, doesn't respond to you or respond to their name,

Y / N 2. Decreased interaction with family members (circle): seeks attention less, less enthusiasm upon greeting, failure to greet family members

Y / N 3. Activity and sleep changes (circle): sleeps more during the day and less at night, experiences nightfrights

Y / N 4. Is restless or has insomnia?

Y / N 5. Bites or screams when touched?

Y / N 6. Any Tremors or Shaking?