

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: _____

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?