



REPTILE INFORMATION SHEET

Please complete and return via fax or email:
(978) 486-0987 • littletonah@yourvetdoc.com

Please fill out this form so that we can use the information to provide the best care possible for your pet.

Contact Information

Owner's First Name: _____ Owner's Last Name: _____
Patient's Name: _____ Species: _____ Age: _____
Sex: Male Female Unknown How was determined: _____
Length of ownership: _____ Quarantine period: _____
Where did you obtain pet? _____

Housing/Environment

Size and type of cage: _____
How often is cage cleaned? _____ What cleaner(s) do you use? _____
Where is the cage located within your home? _____
Temperatures: Cool ____ Warm ____ Basking ____ How are they measured? _____
What types of heat source are you using? _____
What is the cage's humidity? _____ How is it measured? _____
What do you use for a light source? _____
Do you have a broad spectrum (UVB/UVA) bulb? Yes No How often is it changed? _____
Light cycle: Manual Timer Duration: Hours of light _____ Hours of dark _____
Substrate (material on the bottom of the cage): _____
What objects are in the cage? _____
How often do you soak ? _____ When was the last soak? _____
Does your pet spend time outside of enclosure? Yes No Is it supervised? Yes No
Any other reptiles in the house? Yes No
List types and how long you have had them and where they are in relation to this pet:

Other pets: _____
Any changes in the past 6 months: Move Cage Change Travel Loss of People or Pets

Has your pet left the house in the past year? Yes No If so, where? _____

Any contact with reptiles outside the home? Yes No Describe: _____

Diet

Please describe your pet's diet. (Include types, amounts, frequency, live vs killed prey items, etc.)

Do you offer any supplements, vitamins or water additives? Yes No

Type, amount & frequency of administration: _____

Last time you fed? _____ Last time your pet ate? _____

History

Frequency of shed: _____ Last shed? _____

Any issues with shedding? Yes No Describe: _____

Has your pet been examined by another vet? Yes No When? _____

Any injuries, illnesses or surgeries? Yes No Describe:

Have any been seasonal? _____

Currently on any medications? Yes No List: _____

Any adverse reactions to any medications? Yes No Describe: _____

Have you noticed any of the following clinical signs at home? (please circle any applicable)

Cough Sneeze Runny Nose Runny Eyes Behavioral Change

Change in Appetite or Thirst Vomiting/Regurgitation

Other: _____

Please share any additional concerns or information you feel is pertinent to your pet's care:
