



## REPTILE HISTORY QUESTIONNAIRE

Client ID: \_\_\_\_\_ Name: \_\_\_\_\_  
 Client Name: \_\_\_\_\_ Species: \_\_\_\_\_  
 Address: \_\_\_\_\_ Breed: \_\_\_\_\_

Telephone: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Colour: \_\_\_\_\_  
 Age: \_\_\_\_\_

### Identification

What is the reptile's sex?

- Male  Female  Unknown

Reptile's Purpose:

- Pet  Breeder  Other: \_\_\_\_\_

Source of Reptile:

- Store  Breeder  Other: \_\_\_\_\_  
 Wild-caught  Domestic-bred  Adoption/Rescue

Date acquired: \_\_\_\_\_

Has the reptile been quarantined?

- Yes  No  Commercial  Private

Length: \_\_\_\_\_

Did any of those reptiles die or become ill during the quarantine?

- Yes  No  Details: \_\_\_\_\_

### Enclosure

Reptile is kept in:

- Terrarium (mesh or wire sides)  Tank (glass sides)  
 Free in home

Size and location of Reptile's enclosure: \_\_\_\_\_

Hide Box? Y/N

If Yes what type?: \_\_\_\_\_

List types of objects in enclosure (branches, etc):  
 \_\_\_\_\_

Plants in enclosure? \_\_\_\_\_

What substrate do you use on the bottom of the enclosure? (sand, AstroTurf, paper towel, etc)  
 \_\_\_\_\_

How often is the substrate changed? : \_\_\_\_\_

Frequency of enclosure cleaning and products used:  
 \_\_\_\_\_

Other reptiles in same enclosure or room?



Yes

No

List other reptiles on the premises, past or present:

Are any other reptiles sick in the home?

Yes

No

Have any died?

Yes

No

Details: \_\_\_\_\_

List other pets in the home or yard: \_\_\_\_\_

**Light/Heat**

Type of Light (i.e heat, UV, etc): \_\_\_\_\_

How many hours are lights on each day: \_\_\_\_\_

Position of the lighting (direction and distance from animal): \_\_\_\_\_

Exposure to UVB:

None

Direct Sunlight

UVB bulb

How many hours? \_\_\_\_\_

Position of UVB light and how far from the bottom of the cage it is placed: \_\_\_\_\_

**Diet**

What is the current diet (including brands of products):

Insects: \_\_\_\_\_

Fresh fruit/veg: \_\_\_\_\_

Mice/Rats: \_\_\_\_\_

Other: \_\_\_\_\_

For Carnivores: Live prey, Dead prey, both?

For Live prey, do you gut load? Yes, no, what is gut loading?

If live prey are used are they left in the enclosure unsupervised with animal?

Vitamin/Mineral Supplement: \_\_\_\_\_

Water availability: water dish, bottle, mist, other

Method and frequency of cleaning water receptacles: \_\_\_\_\_

**Medical History**

Previous illness or injury: \_\_\_\_\_

Previous medications: \_\_\_\_\_

Any current medications:

Yes

No

Describe:

Date of last examination: \_\_\_\_\_

Last complete shed:

Frequency of shed:

If shed is abnormal, specify how and when last occurred:



**Reproductive history:**

If female, any history of egg laying (or birthing for live birth reptiles)?

- Yes  No

If yes, when was the last clutch? \_\_\_\_\_

How often does egg laying occur? \_\_\_\_\_ How many eggs are produced? \_\_\_\_\_

Are eggs fertile?

- Yes  No

If fertile, are offspring viable when hatched?

- Yes  No Describe issues: \_\_\_\_\_

**Current Health Status**

Reason for visit:

- Wellness Exam  Illness Exam

If ill, describe signs and symptoms: \_\_\_\_\_

How long has problem been occurring? \_\_\_\_\_

Any treatments tried?

- Yes  No If yes, what? \_\_\_\_\_

Mark any of the following symptoms seen:

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Anorexia or reduced appetite | <input type="checkbox"/> Sneezing                  | <input type="checkbox"/> Weakness    |
| <input type="checkbox"/> Regurgitation                | <input type="checkbox"/> Shedding problems         | <input type="checkbox"/> Droopy limb |
| <input type="checkbox"/> Loose droppings              | <input type="checkbox"/> Open mouth breathing      | <input type="checkbox"/> Seizures    |
|   | <input type="checkbox"/> Ocular or nasal discharge |                                      |

Characteristics of droppings:

- Formed  Blood  
 Diarrhea  Increased Urine/Urate

Stool color: \_\_\_\_\_ urine color: \_\_\_\_\_ other changes/abnormalities: \_\_\_\_\_

Any other concerns? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for your information!