

RABBIT MEDICAL HISTORY FORM

Owner: _____	Date: _____	
Pet Name: _____	Breed (common name): _____	
Color: _____	Age / Birthdate: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> Unknown

ABOUT YOUR RABBIT

1. <i>Your rabbit was obtained:</i> <input type="checkbox"/> Breeder <input type="checkbox"/> Pet store <input type="checkbox"/> Friend <input type="checkbox"/> Humane Soc. <input type="checkbox"/> Other: _____
2. <i>How long have you owned this rabbit:</i> _____ <i>Number of rabbits in household:</i> _____
3. <i>Daily quantity of:</i> <input type="checkbox"/> Pellets: _____ <input type="checkbox"/> Hay: _____ <input type="checkbox"/> Treats: _____ <input type="checkbox"/> Other: _____ <i>Feeding schedule:</i> _____
4. <i>How is your rabbit's appetite:</i> <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____ <i>How is your rabbit's attitude:</i> <input type="checkbox"/> Happy-Active-Normal <input type="checkbox"/> Depressed-Lethargic <input type="checkbox"/> Other: _____ <i>Is your rabbit drinking:</i> <input type="checkbox"/> Normally <input type="checkbox"/> More <input type="checkbox"/> Less <i>than usual.</i>
5. <i>Do you notice any of the following:</i> <input type="checkbox"/> Limping <input type="checkbox"/> Eye Discharge <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Sneezing <input type="checkbox"/> Coughing <input type="checkbox"/> Shaking head <input type="checkbox"/> Scratching <input type="checkbox"/> Diarrhea <input type="checkbox"/> Weight loss <input type="checkbox"/> Lethargy / weakness <input type="checkbox"/> Lumps <input type="checkbox"/> Hair loss
6. <i>Does your rabbit use a litterbox consistently:</i> <input type="checkbox"/> Y <input type="checkbox"/> N

YOUR PET'S ENVIRONMENT

1. <i>Does your pet have cage mates:</i> <input type="checkbox"/> Y _____ <input type="checkbox"/> N <i>Number of rabbits in household:</i> _____
2. <i>Type of cage:</i> <input type="checkbox"/> Metal <input type="checkbox"/> Wood <input type="checkbox"/> Glass / Plastic <input type="checkbox"/> Other: _____
3. <i>Cage Size:</i> _____ <i>Toys:</i> _____
4. <i>Bedding Type:</i> _____
5. <i>Cage location in the home:</i> _____
6. <i>How often does your pet come out of the cage for socialization / handling:</i> _____

YOUR RABBIT'S MEDICAL HISTORY

1. <i>Previous veterinary hospital:</i> _____ <i>May we request your records from their office?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>First visit to a veterinarian</i>
2. <i>Has your rabbit had the following in the last 12 months:</i> <i>Physical examination:</i> <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure <i>Fecal sample test:</i> <input type="checkbox"/> Yes date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unsure

COMMENTS: _____