



FERRET HISTORY FORM

Pet's Name: _____ Client: _____ Date: _____

Sex: **M – F - Unsure** Neutered: **Yes – No** Color _____

Is this your first ferret? **Yes - No** Is this your first PET? **Yes - No**

Date of birth _____ (Circle): **actual - estimate**

When did you get your ferret? _____

Source: **Pet Store / Shelter / Pet Show / Breeder / Private Party / Other** _____

Environment

Approximate cage dimensions: H _____ x W _____ x L _____

Substrate on cage floor (Circle): **Newspaper / Care Fresh / Yesterday's News**

Wood Shavings (cedar – pine) / Nothing / Other _____

Does the ferret use a litter box? **Yes – No** Which litter is used? _____

How often is the cage cleaned? _____

Cage Accessories: **Sleeping Bag / Hammock / Towels / Climbing Toys / Shelves**

Cage Toys: **Play Tubes / Chew Toys / Exercise Wheel / Other** _____

Is cage shared with another ferret? **Yes – No** Sex of cage mate: **M – F – Unsure**

Other Pets in the Home: _____

Are they exposed to this pet? **Y – N** In what way? _____

How much time does your ferret get out of its cage per day? _____ minutes/day

Is your pet supervised when it is outside of its cage? **Yes (always) – Usually - No**

Nutrition

Diet (detail everything offered) _____

List everything the ferret eats: _____

Vitamin & Mineral Supplements: _____

Medical History

Name _____

List current medical problems / Primary Complaint: _____

Current treatments or supplements: _____

Please list any previous medical problems (dates & treatment)

Vaccinations (who gave the vaccines? _____)

Distemper? Y – N When _____ Which product _____

Rabies? Y – N When _____ Which product _____

Other Vaccines (include when given) _____

ANY adverse effects? _____

Current Appetite: **Normal – Increased – Decreased – Anorexic** for how long? _____

Stools: **Color** _____ **Consistency** _____ **Amount** _____ **Frequency** _____

Urination: **Color** _____ **Frequency** _____ **Amount** _____ **Difficulty** Y - N

Have you noticed (Circle all that apply):

weight loss, weight gain, masses or lumps (where _____)

abnormal urination, abnormal stools, vomiting, other discharge _____

difficult breathing, coughing, sneezing, nasal discharge _____

excessive shedding, hair loss, itching, skin sores (where _____)

lethargy, inactivity, deep sleep, pain (where _____)

Describe other changes: _____

Previous Veterinary Visits: **Yes – No**

Date of last visit _____

Doctor _____

Clinic _____

Phone _____

Records requested? **Y – N** Received? **Y – N**

Previous Lab Tests / Diagnostics: **Y – N**

Date of Last Testing _____

Complete Blood Count O Chemistry Profile O Fecal Exam O Urinalysis O

Bacterial Culture O Radiograph (X-ray) O Other Tests _____

Results Requested? **Y – N**

Received by Clinic? **Y - N**