



Webster Groves Animal Hospital

Avian Annual Health Care Questionnaire



Please fill out this Avian Health Questionnaire. With your help, we can discover problems early while they can be handled more effectively and less expensively.
Together, we can keep your pet's life happy and healthy.

Pet's Name: _____ Owner's Name: _____ Home Phone Number: _____

Species: _____ Age: _____ Sex: Male Female Unknown Microchip: YES NO

Would you like to know the sex of your bird? YES NO

Date: _____

Current Health History

Current medications: _____

Previous Health problems: _____

Have you noticed any of the following:

Decreased appetite	<input type="checkbox"/> YES <input type="checkbox"/> NO	Increased appetite	<input type="checkbox"/> YES <input type="checkbox"/> NO	Regurgitation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased drinking	<input type="checkbox"/> YES <input type="checkbox"/> NO	Increased drinking	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased defecation (solids)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Increased defecation (solids)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Respiratory Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased urination(liquid/white)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Increased urination(liquid/white)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Beak changes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased feather preening	<input type="checkbox"/> YES <input type="checkbox"/> NO	Increased feather loss	<input type="checkbox"/> YES <input type="checkbox"/> NO	Eye/Cere/Nostril changes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased activity	<input type="checkbox"/> YES <input type="checkbox"/> NO	Egg laying	<input type="checkbox"/> YES <input type="checkbox"/> NO	Behavioral changes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Vocalization changes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Movement/Flying problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Changed perch posture	<input type="checkbox"/> YES <input type="checkbox"/> NO
Decreased sleeping	<input type="checkbox"/> YES <input type="checkbox"/> NO	Increased sleeping	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fluffed up appearance	<input type="checkbox"/> YES <input type="checkbox"/> NO

If "YES" to any of the above, please explain and include when changes occurred:

Husbandry/Grooming History

What is the staple diet of your bird?
 Seed Pellet Other

What brand(s) of food do you feed your bird? _____

Does your bird eat any other foods? YES NO

Describe: _____

What is your feeding schedule for your bird?

Free choice (always available) Three or more daily portions
 Twice daily portions Foraging

Do you provide any mineral supplements? YES NO

Do you provide any vitamin supplements? YES NO

Do you provide any probiotics? YES NO

If "Yes" to the above, describe _____

Wing trim YES NO Date performed _____

Nail trim YES NO Date performed _____

Beak trim YES NO Date performed _____

Recent molt YES NO Date molt began _____

New Birds YES NO Date acquired _____

Quarantined? YES NO

Other pets in home? YES NO

Do you ever board your bird? YES NO

Where? _____

Does your bird go to other bird/pet stores? YES NO

Does your bird ever visit with other birds? YES NO

Does your bird ever go outside? YES NO

If "Yes": In cage Out of cage

Supervised Unsupervised

Thank you for taking the time to complete this questionnaire. Please feel free to ask any questions about the topics on this form during your pet's exam.