

Lakeside Veterinary Center, LLC  
8693 Cherry Lane Laurel, MD 20707  
301-498-8387

Rabbit History form

Owner last name:

Pet's name:

What prompted you to come today? (circle all that apply)

Annual visit

Nail trim

Other concerns

If you circled other concerns, can you describe briefly what those concerns are? \_\_\_\_\_

Has your pet recently experienced any of the following problems? (circle all that apply)

Grinding teeth

Overgrown teeth

Runny nose

Drooling/Wet chin

Coughing

Sneezing

Runny eye

Red eye

Squinting

Trouble breathing

Lethargy

Reluctance to move

Inability to walk/hop

Looks bloated in belly

Lumps or bumps (where?

)

Eye bulging

Holding ear down

Limping

Torn toe nail

Scratching

Dandruff

Fleas

Ticks

Odor from ears

Shaking head

Scratching at ears

Holding head at a tilt

Not eating well (for how long?

)

Soft stool

Smaller pellets

Less pellets than usual

Urinating more

Drinking more than usual

Straining to urinate or have BM

Weight loss

Weight gain

Wounds

Major trauma

Emergency room visits (what for?

)

Pain of any kind

Other signs not listed here: please specify \_\_\_\_\_

What medications, if any, is your pet currently taking?

Critical Care formula

Other (please list with doses if possible): \_\_\_\_\_

What is your rabbit eating?

Pellets (Brand and amount per day):

Hay (Brand, type of hay, amount per day):

Vegetables (types and amount per day):

Other food stuffs: (please specify)

Is there anything else you want the doctor to know or want to talk with the doctor about?