PET PSITTACINE PHYSICAL EXAMINATION FORM

GREG J. HARRISON, DVM, Diplomate ECAMS, Diplomate ABVP Avian Practice
THE BIRD HOSPITAL □ 6147 LAKE WORTH ROAD, LAKE WORTH, FL 33463 □ 561-964-2121 '2001

Client□s Name _____ Date _____ Bird□s Name_____

Species _____ Age _____ Sex: M_____ F_____

DIET

High seed	Yes No
High fruit/vegetable / non-organic	Yes No
High carbohydrates (rice, corn, pasta, bread)	Yes No
Table food	Yes No
High salt treats (corn, crackers, cheese, pizza)	Yes No
No supplemental vitamins/minerals/trace minerals	Yes No
Other (protein, nuts, etc.) _____	
Formulated diet (brand and type) _____	
□ Food contains artificial colors/preservatives	Yes No
□ Food dunked in water	Yes No
□ Food left out over one day	Yes No
□ Food not stored in original bags	Yes No
□ Food tastes stale or rancid	Yes No
□Food left open longer than every 4-6 weeks	Yes No
□ Food allows powdering & waste	Yes No
Possible pesticides in diet	Yes No
Non-pure water (Source _____)	Yes No

HUSBANDRY

Inadequate cage size	Yes No
Inadequate hygiene	Yes No
Sandpaper perch	Yes No
Cement perch	Yes No
Dirty perches	Yes No
(perch type) _____	
Exposure to non-quarantined birds	Yes No
Boarded at pet shop _____ (date)	Yes No
Corn cob or similar flooring	Yes No

TOXINS

Insecticides (ant/flea/roach/mosquito)	Yes No
Fungicides, herbicides	Yes No
Preservatives	Yes No
Disinfectants	Yes No
Heavy metals (lead/zinc)	Yes No
Mycotoxins in diet (rancid food)	Yes No
Hair spray	Yes No
Solid or plug-in air freshener	Yes No
Carpet cleaner (eg, Carpet Fresh®)	Yes No
Mite protector	Yes No
Cigarette smoke	Yes No
Teflon® (heaters, pans, etc)	Yes No

MEDICAL HISTORY

Treatment for chronic bacteria	Yes No
Treatment for chronic yeast	Yes No
Treatment for chronic fungus	Yes No
Treatment for chlamydia	Yes No
Treatment for toxin exposure	
Exposure to other birds (viral)	Yes No
Vaccinations: type, date _____	
Other _____	

WEIGHT

Body weight_____ g

Emaciation	Yes No
Obesity	Yes No
Lipoma	Yes No

FEATHERS

Abnormal molt	Yes No
Frequency of molt (times per year)	_____
Last molt	_____/_____/_____
Chronic pin feathers (fail to open)	Yes No
Saw-toothed edges (failure to zip)	Yes No
Bald spots	Yes No
Broken, malformed or bent	Yes No
Lack of powder down	Yes No
Dull appearance	Yes No
Failure to mist with water	Yes No
Stained or dirty	Yes No
Stress lines	Yes No
Thin-veined	Yes No
Transparent	Yes No
Flexibility at 180□ tip to base: □ Breaks	Yes No
□ Bends	Yes No
□ Indents	Yes No
□Straight	Yes No
Over-preening	Yes No
Picked	Yes No
Feathers (chewed/consumed)	Yes No
Malcolored (e.g. black feathers)	Yes No
If yes, describe _____	
Dystrophy	Yes No
Frequently fluffed	Yes No
Parasites	Yes No

NAILS & BEAK

Overgrown	Yes No
Unshed, flaky or rough	Yes No
Twisted nails	Yes No
Other abnormalities: _____	
_____	

SKIN

Flaking	Yes No
Lacking luster	Yes No
Itchy	Yes No
Balding (feet)	Yes No
Bumblefoot	Yes No
Lack of stretch	Yes No
Cannibalized (mutilation)	Yes No
Slow healing sores/rashes	Yes No
Change in epithelium in cavities	Yes No
Dry or crusty: □ cloaca	Yes No
□ nares	Yes No
□ eyes	Yes No
Ears (head or twitch/redness)	Yes No
Eyes (redness)	Yes No

LIMBS

Weak tendons and ligaments	Yes No
Pain in legs/wings (after fall)	Yes No
Bent: □ legs	Yes No
□ wings	Yes No
□ sternum	Yes No
□ spine	Yes No
Abnormal joints	Yes No
Abnormal posture	Yes No

BLEEDING

From wing tips Yes No
Excessive (from cut or injury) Yes No
Droppings Yes No
Slow clotting Yes No
Bleeding/bruising of: □ skin Yes No
□ beak Yes No
□ feathers Yes No
Black feces Yes No
Blood occult in feces Yes No
Other _____

SWELLING

Abdominal Yes No
Rapidly growing lump Yes No
Swollen salivary glands of: □ oral cavity Yes No
□ intermandibular space Yes No
Tongue Yes No
Soft palette Yes No
Other _____

RESPIRATORY

Nasal discharge Yes No
Tail-bobbing Yes No
Dyspnea Yes No
Infraorbital sinus swollen Yes No
Vocalization: □ voice change Yes No
□ loss of voice Yes No
□ clicking Yes No
□ wheezing Yes No
Perpetual sneezing Yes No
Dirty feathers over nares Yes No
Dry (lith), hard mass in nares Yes No
Nares enlarged or distorted Yes No
Results of auscultation _____
Rhinitis, atrophic Yes No
Choana: □ discharge Yes No
□ loss of papilla Yes No
Other _____

NEUROLOGIC

Weak blink Yes No
Weak jaw Yes No
Poor tongue control Yes No
Weak grip Yes No
Paralysis Yes No
Wing droop Yes No
Other _____

BEHAVIOR

Polyphagia Yes No
Anorexia Yes No
Copraphagia Yes No
Polydipsia Yes No
Drinking less Yes No
Vomiting Yes No
Regurgitating Yes No
Sleepy Yes No
Weak Yes No
Does *less:* □ talking Yes No
□ playing Yes No
□ singing Yes No
Does *more:* □ biting Yes No
□ chewing Yes No
□ screaming Yes No
□ throwing objects Yes No
Alpha bird Yes No
Spoiled Yes No
Overly sensitive to sudden noises Yes No
Falls off perch at night Yes No
Separation anxiety Yes No
Other _____

REPRODUCTIVE

Sexual display (male, female) Yes No
Infertility Yes No
Egg peritonitis Yes No
Chronic laying Yes No
Erratic laying Yes No
Small clutches Yes No
Hatching problems Yes No
Dead-in-shell Yes No
Abnormal or missing shell Yes No
Soft shell Yes No
Small eggs Yes No
Egg bound Yes No
Nest building activity Yes No
Last egg laid (date) _____/_____/_____
Number of eggs _____
Eggs left with hen Yes No

DROPPINGS

Decreased/increased amount Yes No
Yellow or green in urine Yes No
Yellow or green in urates Yes No
Green feces Yes No
Increased liquid in urine Yes No
Increased powdered urates Yes No
White, fluffy droppings Yes No
Undigested food in feces Yes No
Parasites or eggs in feces Yes No
Bubbly, gaseous droppings Yes No
Scant feces Yes No
Diarrhea Yes No
Pasting of vent Yes No
Glucose in urine Yes No
Blood in urine Yes No
pH of feces _____

GRAM'S STAIN OF DROPPINGS

Low numbers (#) of bacteria Yes No
High #□s gram-positive rods (>90%) Yes No
Low #□s gram-positive cocci (<10%) Yes No
Gram-negative rods (>1%) Yes No
More than 5-10 yeast per field Yes No
More than 10% budding yeast Yes No
High G+ cocci Yes No
Clostridia present Yes No

OTHER

Ophthalmic disorders Yes No
Cardiac disorders Yes No

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