

# PET PSITTACINE PHYSICAL EXAMINATION FORM

GREG J. HARRISON, DVM, Diplomate ECAMS, Diplomate ABVP Avian Practice



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) _____		
<input type="checkbox"/> Food contains artificial colors/preservatives	Yes	No
<input type="checkbox"/> Food dunked in water	Yes	No
<input type="checkbox"/> Food left out over one day	Yes	No
<input type="checkbox"/> Food not stored in original bags	Yes	No
<input type="checkbox"/> Food tastes stale or rancid	Yes	No
<input type="checkbox"/> Food left open longer than every 4-6 weeks	Yes	No
<input type="checkbox"/> 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 (perch type) _____	Yes	No
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 <sup>®</sup> )	Yes	No
Mite protector	Yes	No
Cigarette smoke	Yes	No
Teflon <sup>®</sup> (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:		
<input type="checkbox"/> Breaks	Yes	No
<input type="checkbox"/> Bends	Yes	No
<input type="checkbox"/> Indents	Yes	No
<input type="checkbox"/> 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:		
<input type="checkbox"/> cloaca	Yes	No
<input type="checkbox"/> nares	Yes	No
<input type="checkbox"/> 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:		
<input type="checkbox"/> legs	Yes	No
<input type="checkbox"/> wings	Yes	No
<input type="checkbox"/> sternum	Yes	No
<input type="checkbox"/> 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: <input type="checkbox"/> skin	Yes No
<input type="checkbox"/> beak	Yes No
<input type="checkbox"/> 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: <input type="checkbox"/> oral cavity	Yes No
<input type="checkbox"/> 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: <input type="checkbox"/> voice change	Yes No
<input type="checkbox"/> loss of voice	Yes No
<input type="checkbox"/> clicking	Yes No
<input type="checkbox"/> 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: <input type="checkbox"/> discharge	Yes No
<input type="checkbox"/> 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
Coprophagia	Yes No
Polydipsia	Yes No
Drinking less	Yes No
Vomiting	Yes No
Regurgitating	Yes No
Sleepy	Yes No
Weak	Yes No
Does less: <input type="checkbox"/> talking	Yes No
<input type="checkbox"/> playing	Yes No
<input type="checkbox"/> singing	Yes No
Does more: <input type="checkbox"/> biting	Yes No
<input type="checkbox"/> chewing	Yes No
<input type="checkbox"/> screaming	Yes No
<input type="checkbox"/> 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# <input type="checkbox"/> s gram-positive rods (>90%)	Yes No
Low# <input type="checkbox"/> 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
_____	
_____	
_____	
_____	

