Animal Dermatology Clinic

PATIENT HISTORY

Client Name _____ Pet's Name _____
Reason(s) for visit today: _____
Age of pet when acquired: _____ Current Age: _____ Approx date problem started: _____
Is your pet: ☐ Intact ☐ Altered If altered, at what age? _____
Is condition: ☐ Seasonal ☐ Continuous If problem is now continuous, was it initially seasonal? ☐ Yes ☐ No
Is there a time when the disease is: ☐ Less severe? ☐ Itching is less intense? When? _____
Percent of time pet is kept: Indoors _____% Outdoors _____%
Are symptoms worse: ☐ Indoors ☐ Outdoors ☐ Morning ☐ Night Describe: _____
What was the problem like initially? ☐ Normal skin, but itchy ☐ Hair loss ☐ Rash ☐ Pimples ☐ Redness
Where did problem start? ☐ Nose ☐ Ears ☐ Neck ☐ Back ☐ Rump ☐ Tail ☐ Front legs
☐ Front paws ☐ Back paws ☐ Back legs ☐ Eyes ☐ Chest ☐ Abdomen ☐ Groin
Has it spread? ☐ Yes ☐ No If so, where? _____
Does your pet scratch, rub, chew, lick or bite any of the following areas? ☐ Nose ☐ Muzzle ☐ Eyes
☐ Back paws ☐ Chest ☐ Back ☐ Front legs ☐ Rump ☐ Tail ☐ Abdomen ☐ Back legs ☐ Ears
☐ Neck ☐ Front paws ☐ Armpits ☐ Groin ☐ Inner thighs and legs
How itchy is your pet on a scale of 1 – 10 (10 being the worst)? _____
Comments: _____
Does your pet do any of the following? If yes, list frequency and description:

Cough	☐ Yes	☐ No	_____	Sneeze	☐ Yes	☐ No	_____
Runny eyes	☐ Yes	☐ No	_____	Get ear infections	☐ Yes	☐ No	_____
Diarrhea	☐ Yes	☐ No	_____	Loss of appetite	☐ Yes	☐ No	_____
Vomit	☐ Yes	☐ No	_____	Drink excessively	☐ Yes	☐ No	_____
Limp	☐ Yes	☐ No	_____	Urinate excessively	☐ Yes	☐ No	_____

Do you have other pets? ☐ Yes ☐ No Species: _____
If you have other pets, are they affected? ☐ Yes ☐ No Describe: _____
Do you or anyone in your household have skin problems? ☐ Yes ☐ No Describe: _____
Do your pet's littermates or parents have skin problems? ☐ Yes ☐ No Comments: _____
If yes, explain: _____
Do you use flea control on your pet? ☐ Yes ☐ No Type: _____ How often? _____
Do you use environmental flea control in your home and/or yard? ☐ Yes ☐ No Frequency: _____
Please list medications/injections your pet has taken for the skin condition: _____
_____
Other medications your pet is receiving: _____
Did any medications help the problem? ☐ Yes ☐ No Which one(s)? _____
Please list any vitamins, food supplements, etc. your pet has been given: _____
How often do you bathe your pet and what shampoos are used? _____
What is your pet's current diet, including treats? _____
How long has your pet been on this diet? _____
Please circle the number of bowel movements your pet has per day: 1 2 3 4 5 6
Has your pet receive treatment for stomach or intestinal problems? ☐ Yes ☐ No If yes, explain: _____
_____
Please circle how many times your pet was treated for this skin condition prior to visiting us: 1 2 3 4 5 6
Additional comments: _____
_____