



Animal Dermatology Clinic

Advancing the Art of Veterinary Dermatology

PATIENT HISTORY FORM

Date: _____

CLIENT NAME _____ PET'S NAME _____

Chief complaints(s)

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 Night Morning

What was the problem like initially? Normal skin, just itchy Hair loss Rash Pimples Redness

Where did problem start? Nose Eyes Ears Neck Back Rump Tail

Front legs Front paws Back paws Back legs 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 Ears

Neck Chest Back Rump Tail Armpits Front legs Front paws

Back paws Back legs Abdomen Groin Inner thighs and legs

Comments:

Does your pet do any of the following? If yes, list frequency and description:

Cough Yes No _____

Runny eyes Yes No _____

Diarrhea Yes No _____

Loss of Appetite Yes No _____

Urinate excessively Yes No _____

Sneeze Yes No _____

Get Ear Infections Yes No _____

Vomit Yes No _____

Drink excessively Yes No _____

Limp Yes No _____

Do you have other pets? Yes No List 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

If yes, explain:

Do you use flea control on your pet? Yes No Type: _____

Do you use environmental flea control in your home and/or yard? Yes No Frequency: _____

Please list medication/injections your pet has been on for the skin condition:

Other medications your pet is on:

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 check the number of bowel movements your pet has per day: 1 2 3 4 5 6

Has your pet received treatment for stomach or intestinal problems? Yes No

Please check mark how many times was your pet treated for this condition prior to visiting our clinic:

1 2 3 4 5 6

Additional Comments: