DERMATOLOGY HISTORY FORM

1. What is the main reason for your visit? __________________________________________________________________________________________

2. At what age did the problem start?______ Onset: Sudden________ Slow________

3. Is there a seasonal influence? No______ Summer______ Fall______ Spring______ Winter______

4. Where on the body did the skin problem start?___________________________________________________________

5. What did the skin condition look like at the beginning?_____________________________________________________

6. Has the problem become progressively worse?______ Describe how.___________________________________________

7. Are any other pets in the household affected with a skin problem?__________________________________________

8. Are any people in the household affected with a skin problem?_______________________________________________

9. Describe animal’s environment: ___________________________________________Indoor %___ Outdoor %___

10. Have you noticed your pet rubbing/scooting/chewing/licking/head shaking/scratching at ears/scratching/grooming
   body excessively? Circle all that apply. When? Constant______ Sporadic______ Nightly______

11. On a scale of 1-10 with 1 being slightly itchy and 10 tremendously itchy, describe how itchy:_________________________

12. Has your pet had any recent or chronic digestive problems? ____________ Current diet ________________________________

13. Female pet: (a) age spayed?______ (b) had abnormal or irregular cycles?______ (c) been pregnant?______

14. Male pet: (a) age neutered?______ (b) are other male dogs attracted to your male dog?____________________________

15. Previous diagnostic test for skin disease and results:_________________________________________________________

16. Medical history – Previous non skin diseases, treatment, and results:___________________________________________

17. List any medications or supplements you have used on your pets, including shampoos, ointments and OTC products:
   _____________________________________________________________________________________________

18. Have any of the above treatments helped? If so, which ones?_________________________________________________

19. Please list any current medications, including dosages: ______________________________________________________

20. Please list any flea control products you have used recently: ___________________________________________________

21. Do you bathe in between flea preventive applications?___________

22. Any other facts that you think would be helpful ___________________________________________________________

23. Please check if any of the following are present or have occurred in the past. PR = present PA = past

   Greasy skin or coat______ Dandruff______ Dark patches on skin______ Light patches on skin_____ Thickened
   skin______ Demodex (mange) _______ Scabies_______ Ringworm______
   Open sores______ Scabs_______ Lumps_______ Hair Loss_______ Hairballs_______ Fleas_______
   Ticks__________ Ear mites_______ Pimples_______