Dr. Steven Shaw **Dr. Jennifer Mills**

BROADVIEW PET MEDICAL CENTER

Patient Dermatological History Form

Owner Name: _____ Date: _____
Pet's Name: _____ Pet's Age: _____
Breed: _____ Gender: _____
One of the most important things you can do for your pet that has skin problems is to provide us with detailed information on your pet's problems.

1. What are your pet's problems *currently*: (check all that apply)
Hair loss ( )
Scratching, chewing, licking, rubbing skin ( )
Red bumps, pimples, scabs ( )
Ear infections ( )
Skin infections ( )
Excessive dandruff, scaling ( )
Skin odor ( )
Nail infections or nail loss ( )
Other (describe) ( ) _____

2. *How long* has/have the current problem(s) been present? _____

3. What did your pet's problems look like *initially*? _____

4. What areas of your pet are affected? (check all that apply)
Ears ( ); Face ( ); Neck ( ); Armpits ( ); Rump/tail area ( ); Underside ( );
Groin/inner thighs ( ); Legs/paws ( ); Anal/genital area ( ); Other ( ) _____

5. Has your pet's skin problem changed? Yes ( ) No ( ).
If yes, please describe: _____
If yes, what areas are affected now? _____
_____

6. What treatment has your pet received for his/her skin problem?
Check all that apply and list or circle names if possible:
( ) Antibiotics (list) _____
( ) Oral cortisone e.g.: prednisone, Vetalog, Dexamethasone
( ) Cortisone/steroid injections
( ) Antihistamines e.g.: Benadryl, Atarax, chlorpheniramine
( ) Fatty acids/oils, fish oil capsules, Derm caps, vegetable oils
( ) Ivermectin (anti-mite injections)

( ) Ear ointments or drops (please list) _____
( ) Herbal or homeopathic remedies (please list) _____

7. Did medication/therapy help your pet's problem(s)? Yes ( ) No ( )
If no, go to 8. If Yes, which medication was the most effective?
_____

Did the lesions resolve with this medication/therapy? Yes ( ) No ( )

Did the lesions return after the medication/therapy was stopped? Yes ( ) No ( )

How long did it take for the lesions to return? _____ (weeks/months)
circle

8. On a scale of 1-10 with 1= occasional chewing or scratching and 10= severe constant scratching that keeps you up at night, how would you rate your pet's level of itchiness now? (circle number from 0-10):

0 1 2 3 4 5 6 7 8 9 10

How would you rate chewing or scratching while your pet was on antibiotics? _____ (1 – 10) Not given antibiotics ( ).

How would you rate chewing or scratching while your pet was on antihistamines? _____ (1 – 10) Not given antihistamines ( )

How would you rate chewing or scratching while your pet was on steroids? _____ (1 – 10) Not given steroids ( ).

9. Is/are your pet's problem(s) intermittent ( ) or continual ( )?

10. Is there *currently* a relationship between your pet's problem(s) and the season of the year? Yes ( ) No ( ) If yes, please check the season(s) when the problem is worse: Spring ( ); Summer ( ); Fall ( ); Winter ( )

The problem begins in _____ (month)
In the past was there a relationship between your pet's problem(s) and the season of the year? Yes ( ) No ( ) If yes, what seasons?_____

11. Do you have any other pets? Yes ( ); No ( ); Please list any other pets_____

12. Do your other pets have similar skin conditions? Yes ( ); No ( ); Does not apply ( ). If yes, what are the other pet's problems? _____
_____

13. Describe the indoor environment of your pet – such as bedding, where

he/she sleeps, etc. _____

14. Describe the outdoor environment (grasses, weeds, trees, wooded areas, etc) _____

How many hours of the day is your pet outdoors? _____

15. Have you noticed fleas on your pet recently? Yes ( ); No ( )

16. What flea products do you currently use? _____

Flea products not used ( ).

17. Has any person in your household had skin problems since your pet started having skin problems? Yes ( ); No ( ) If yes, please describe
_____

18. What oral or injectable medication is your pet presently receiving and when was it last given? _____

19. Are any medications currently being used topically on your pet (include ear medications)? Which one(s)? _____ Applied where?
_____

20. Which food is your pet currently receiving? _____
How long? _____

21. Does your pet receive anything else to eat? E.g. table food, treats, biscuits, vitamin supplements, or rawhide chews given? Please list:
_____

22. Does your pet have any other previously diagnosed medical or surgical problems unrelated to the skin disorder? Yes ( ); No ( ) Please describe:
_____
_____

Is your pet receiving any medication for this disorder? Please list medications: _____
_____

23. Have you noticed any change in the health or behavior of your pet that coincided with the development of the skin condition? (e.g. changes in food or water intake, changes in urination or defecation, changes in activity level) Yes ( ) No ( ) Please list: _____
_____

24. Has your pet ever been on a special food elimination diet? Yes ( ); No ( );
If yes, what commercial brand of food or home-cooked diet ingredients were used and for how long? _____
_____

Were treats, table food, biscuits, rawhides, or chewable medications given while on the diet? Yes ( ); No ( )

25. **For Dogs**: Is your pet currently on heartworm preventative (Heartgard, Interceptor, Filaribits)? Yes ( ); No ( ) If yes, is it a chewable?
Yes ( ); No ( )

26. **For Cats**: Was your pet tested for feline leukemia virus (FeLV)?
Yes ( ); No ( )

27. Has you pet always lived in this part of the country? Yes ( ); No ( )
If no, where did you live before and when did you move?
_____
_____

Thank you for completing the questionnaire. Please give to one of the receptionists when you arrive for your appointment.