Shuswap Veterinary Clinic

Dermatology history form

Date: _____ Pet's Name: _____

Your name:_____

Bring this form completed for your appointment.

1. What skin or ear problem are you bringing your pet in for? _____

2. How long has the problem been present? _____ How old was your pet when the problem first started?_____

3.. When the problem started, did it come on suddenly or gradually over a period of time? _____

4. What did the skin or ear problem look like initially? _____

5. How has it changed or spread? _____

6. The problem has been (check one):

☐ Continual, even with medication ☐ Continual but better with medication ☐ Intermittent or sporadic

7. Is the problem worse during certain times of the year? If so, when? _____

8. Over the past year, how itchy has your pet been during a typical outbreak of skin or ear disease? Use a scale of 1 to 10 with 1 meaning an occasional scratch, like a normal person or animal might do, and 10 meaning constant, severe scratching. _____

9. Using the same 1 to 10 scale, how itchy has your pet been over the past month? _____

10. Is your pet receiving any treatment now? If yes, what kind? _____

11. When did your pet last receive any medication, and what medication was it? _____

12. What do you feed your pet now?_____

13. Have any different diets been tried as treatment? If so, list the brand name and for how long you fed it:

_____

14. How often do you usually bathe your pet? With what? _____

15. When was the last time you saw a flea on your pet or another pet in the household? _____

16. Do you routinely use flea or tick preventive products on your pet (list type)? _____

17. How old was your pet when you obtained him/her? Where did you get your pet? _____

18. What other pets are in the household? _____

19. Do any of the other pets have skin problems? Do any people in the household have skin problems? _____

20. What percentage of the day and night does your pet spend indoors vs. outdoors?

Indoors ____% Outdoors ____%

21. Other than skin disease, does you pet have any diagnosed medical problems? _____

22. Please list any other clinical signs your pet has that have not been described above or anything else you suspect might be contributing to your pet's skin or ear disease?

_____

_____

_____

_____

Please turn over and continue on reverse side.

23. In the following table, check which clinical signs have been present and how severe they have been over the entire course of the pet's skin or ear problem. (Check one box for each clinical sign.)

Clinical sign	Never occurs or none	Occurs rarely or slight	Occurs occasionally or moderate	Occurs often or severe
Scratching/licking/biting at self				
Hair loss or poor regrowth of hair				
Increased redness to skin				
Small red spots, pimples, bumps, rash				
Dandruff, flakiness, scaliness of skin				
Increased odour of skin or coat				
Crusty or scabby patches on skin				
Open, raw sores				
Areas that ooze blood or pus				
Eyes—redness, irritation, itching, discharge				
Change in colour or texture of hair				
Darkening of areas of the skin				
Loss of pigment of skin - black parts turn pink				
Ear infections				
Fleas seen on pet				
Diarrhea or loose stools				
Vomiting				
Sneezing or wheezing				
Changes in pet's usual personality				
Changes in pet's usual activity level				
Weight loss or weight gain				
Changes in pet's appetite				
Changes in amount of water consumed				
Changes in urinary habits				

24. How much licking, biting, chewing, scratching, or rubbing does your pet do on the following areas of the body? (Check one box for each clinical sign.)

Body area	Not itchy	Mildly itchy	Moderately itchy	Severely itchy
Feet/paws				
Legs/arms				
Abdomen (belly)/genital area				
Armpits/chest/sides of body				
Face/eyes				
Ears/ear flaps				
Along the back or rump				
The tail itself				
Anal area				

25. It is important that we know which types of medications were given to your pet in the past and whether they helped. On the list of medications below, check if they have been given and, if so, how much relief they produced. (Check box "Yes" if given and then how much the treatment helped.)

Treatment or medication	Was it ever given?			If given, how much did it help?		
	Yes	No	Not sure	Did not help	Helped some	Helped a lot
Cortisone pills or shots (steroids, Temaril, prednisone, Vetalog, anti-itch pills)						
Antibiotics alone (with no other medication given at the same time)						
Antihistamine (Benadryl, Zyrtex, etc.)						
Antifungal medications (ketoconazole, etc.)						
Cyclosporine (Atopica)						
Apoquel						
Allergy shots or drops						