

Dermatologic Questionnaire: To help us get a better idea of the types of potential skin problems your pet has had, please take a few minutes and fill out the following questionnaire. If unsure of a question, please leave it blank.

Pet Name: _____ Client Name: _____

Age when you acquired pet: _____ Age Now: _____

Why is your pet here today: _____

How long has this been going on? _____

Is the problem seasonal or continuous? Seasonal Continuous

Was the problem initially seasonal? Yes No

Is there a time when the disease is less severe or the itching less intense? Yes No

What did the problem initially look like? (Please check)

Normal Skin just itchy Hair Loss Rash Pimples Redness

Where did it start? (Please check)

Nose Eyes Ears Neck Back Rump
 Tail Arm Pits Front Legs Back Legs Thighs Back Paws
 Chest Abdomen Groin

Has it spread? Yes No

Is so where? _____

Does your pet scratch, rub, chew, lick or bite the following (Please check).

Nose Eyes Ears Neck Back Rump
 Tail Arm Pits Front Legs Back Legs Thighs Back Paws
 Chest Abdomen Groin

Was the itching the first thing you noticed? Yes No

Do you have other pets? Yes No

If yes, please describe: _____

Do you have any skin problems? Yes No

If yes, please describe: _____

Do any people in the household have skin problems? Yes No

If yes, please describe: _____

Percent of the time the pet is indoors? _____ Outdoors: _____

PLEASE TURN OVER AND FILL OUT SECOND SIDE

What is the primary indoor flooring surface? Carpet Tile Wood
Other _____

If carpeting, does it contain wool? Yes No

What is the patient's outdoor environment? (Please check all that applies)

Grass Rock Dirt Cement Outdoor Carpeting
 Pool Other: _____

Where or when are the symptoms the worst? Indoors Outdoors Night Morning

If a female, were or are there normal heat cycles? Yes No

If a male, does he have normal interest in females? Yes No

Do any relatives of your pet have any skin problems that you are aware of? Yes No

If yes, please explain: _____

What type of flea control do you use? None Dips Sprays Collars
 Baths Spot-ons

What Brands and Frequency? _____

Do you use insecticides in your home? Yes No Frequency? _____

Please check medications that your pet has been on for the problem:

Antihistamines Steroid Pills Steroid Injections Antibiotics
Other: _____

Did any help the problem? Yes No Which: _____

Any medications, vitamins, food supplements? _____

What is your pet's regular diet? _____

Does your pet have any other health problems? (Please check)

Cough Sneeze Runny Eyes Vomiting Diarrhea
 Tires easily Limp Drinks excessively Urinates excessively

How often do you bathe your pet? _____

What shampoo and / or conditioner do you use? _____

Other comments: _____
