

Dermatologic History Sheet

Client Name _____ Pet's Name _____ Date _____

1. Chief complaint(s) _____
2. Age of pet when you acquired him/her _____ Current Age _____
3. Approximate date when problem first started? _____
4. Duration of the problem? seasonal continuous problem?
5. If the problem is now continuous, was it initially seasonal? Yes No
6. Is there a time when the disease is less severe or the itching is less intense? _____
7. What was the problem like initially? (please check all that apply)
 Normal skin, just itchy Hair loss Rash Pimples Redness
8. Where did the problem start? (please check all that apply)
 Nose Muzzle Eyes Ears Neck Back Rear End Tail Front legs
 Front paws Back legs Back paws Armpit Chest Stomach Groin
9. Has it spread? Yes No If so, where? _____
10. Does your pet scratch, rub, chew, lick or bite the following areas? (please check all that apply)
 Nose Muzzle Eyes Ears Neck Back Rear End Tail Front legs
 Front paws Back legs Back paws Armpit Chest Stomach Groin
Comments _____
11. Do you have other pets? Yes No If yes, please describe _____
12. Do any of your other pets have skin problems? Yes No If yes, please describe _____
13. Do any people in your household have skin problems? Yes No
If yes, please describe _____
14. Percent of time your pet is confined: Indoors _____ Outdoors _____
15. Are symptoms worse indoors, outdoors, night or morning? _____
16. Is your pet spayed/neutered? Yes No If yes, at what age? _____
17. If your pet is female, are or were her heat cycles normal? Yes No
18. If your pet is male, does he have normal interest in females? Yes No
19. Do any relatives of your pet have any skin problems that you know of? Yes No
If yes, please describe _____
20. Do you use flea control? Yes No If yes, what type? _____ Frequency _____
21. Do you use insecticides in your home? Yes No If yes, which? _____ Frequency _____
22. Please list any medication/injections your pet has been on for this problem?

23. Did any of the treatments help? Yes No If yes, which? _____
24. What vitamins, food supplements, etc. have been given?

25. What is your pet's regular diet? _____
26. Does your pet do any of the following? If yes, list frequency and description:
 Cough _____ Sneeze _____ Runny eyes _____
 Vomit _____ Diarrhea _____ Limp _____
 Drink excessively _____ Urinate excessively _____ Ear infections _____
27. Has your pet's appetite changed? Increased Decreased Unchanged
28. Additional comments? _____