

PATIENT HISTORY



Dermatology Center for Animals

430 Yale Avenue North • Seattle, WA 98109
Tel 206 508-5500 • Fax 206 508-5520

Patient Name: _____

Species: _____ Breed: _____

Sex: _____ Age: _____

Weight: _____ Color: _____

Patient Owner: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

What skin problems does your pet have?

- Itch (scratching, licking, chewing, excessive grooming)
- Hair loss
- Persistent infections, rashes, scabbing or sores
- Toe nail problems

How old was your pet when these problems began?

- Less than 6 months of age
- Less than 1 year of age
- 1 - 3 years of age
- Greater than 3 years of age (please specify): _____

How long have these problems been present? _____

Is your pet itchy

On a scale of 1 - 10 (1 = normal, 10 = severely itchy), how itchy is your pet?

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Feet _____ | <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Face _____ | <input type="checkbox"/> Ears _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Back _____ | <input type="checkbox"/> Scooting (rear) _____ | <input type="checkbox"/> Other: _____ |

Is your pet's itch present year round? YES NO Has your pet lived in another state? YES NO

Is your pet's itch worse during certain seasons? Please check (spring / summer / fall / winter)

- SPRING SUMMER FALL WINTER

PREVIOUS TESTING

Has your pet had prior tests performed for the current problem? Check all that apply:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Skin scrapings | <input type="checkbox"/> Allergy testing | Lab work: <input type="checkbox"/> Blood work (CBC / Chemistry) | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> Skin biopsy | <input type="checkbox"/> X-rays or CAT scan | <input type="checkbox"/> Thyroid testing | <input type="checkbox"/> FeLV / FIV (cats) |
| <input type="checkbox"/> Skin culture | | <input type="checkbox"/> Cushing's testing | |

TREATMENT HISTORY

Has your pet received or been prescribed any of the following? Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Antibiotics: (Please list names) _____ _____ _____ | <input type="checkbox"/> Antihistamines: <input type="checkbox"/> Benadryl (diphenhydramine) <input type="checkbox"/> Zyrtec (cetirizine) <input type="checkbox"/> Chlortrimeton (chlorpheniramine) <input type="checkbox"/> Atarx (hydroxyzine) <input type="checkbox"/> Claritin (loraditine) <input type="checkbox"/> Tavist (clemastine) <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anti-fungals | |
| <input type="checkbox"/> Bathing / topicals <input type="checkbox"/> Shampoos: (# _____ per week / # _____ per month) <input type="checkbox"/> Sprays / wipes: (# _____ per week / # _____ per month) | |

PATIENT HISTORY (CONTINUED)

Allergy Vaccine: YES NO

How long was the vaccine given? _____

How often was the vaccine given? _____

Steroids: YES NO

When was last dose given? _____

What form was given? Injection Pills Did it help? YES NO

Side effects noted: _____

Atopica: YES NO

Did it help? YES NO

Side effects noted: _____

Apoquel: YES NO

Did it help? YES NO

Side effects noted: _____

Does your pet suffer from ear infections? YES NO

Do you clean your pets ears? YES NO

If YES, how often do you clean them? _____

Does your pet show any of the following signs at home? Check all that apply:

Increased drinking

Increased urination

Increased appetite

Panting

Weight gain

Weight loss

Frequent vomiting

Has a strict (prescription) diet trial been attempted? YES NO

What diet(s) have been tried? (Please list all) _____

Please check the brands / products used:

Frontline

Advantix

Trifexis

Frontline Plus

Seresto Collar

Heartgard

Advantage

Revolution

Other: _____

Advantage Multi

Comfortis

Other: _____

How often is heartworm preventive given?

Monthly

Seasonally

Not given

How often is flea / tick preventive given?

Monthly

Seasonally

Not given

Where does your pet spend most of their time?

Indoors

Outdoors

Equally indoors and outdoors

Do you have any other pets in the house?

Dog(s)

Cat(s)

Other

Do these animals exhibit any similar skin problems? YES NO

Medical History

Does your pet have any of the following medical conditions?

Heart condition / murmur

Cushing's disease

History of pancreatitis

Diabetes

Seizures

Kidney disease

Hypothyroidism