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DERMATOLOGY HISTORY NEW PATIENT

Date: _____

Pet Name _____ Age now _____ Age when problem started _____

Primary concern/ problem _____ Duration _____

Other pets/animals in the household: _____

Are any in-contact pets/humans affected by this condition or possibly related problem? YES or NO

Are any littermates to this affected pet demonstrating similar problems? YES or NO

Has your pet always lived in this area? YES or NO

What was the first thing you noted when problem started? (itch, scratch, rash, red skin, scale, crust, etc.) _____

Where on the body did the problem start?

<input type="checkbox"/> Nose	<input type="checkbox"/> Neck	<input type="checkbox"/> Under tail	<input type="checkbox"/> Chest
<input type="checkbox"/> Around eyes	<input type="checkbox"/> Top of back	<input type="checkbox"/> Front legs	<input type="checkbox"/> Nails
<input type="checkbox"/> Mouth/muzzle	<input type="checkbox"/> Rump	<input type="checkbox"/> Back legs	<input type="checkbox"/> Tail
<input type="checkbox"/> Ears/ear flaps	<input type="checkbox"/> Sides of trunk	<input type="checkbox"/> Front paws	<input type="checkbox"/> Back paws
<input type="checkbox"/> Abdomen/stomach	Other _____		

Has the problem spread? YES or NO . If yes, to what body site(s): _____

Does your pet itch? YES or NO (ITCH = licking, biting, scratching, chewing, rubbing, rolling) Where?

<input type="checkbox"/> Nose	<input type="checkbox"/> Neck	<input type="checkbox"/> Under tail	<input type="checkbox"/> Chest
<input type="checkbox"/> Around eyes	<input type="checkbox"/> Top of back	<input type="checkbox"/> Front legs	<input type="checkbox"/> Nails
<input type="checkbox"/> Mouth/muzzle	<input type="checkbox"/> Rump	<input type="checkbox"/> Back legs	<input type="checkbox"/> Tail
<input type="checkbox"/> Ears/ear flaps	<input type="checkbox"/> Sides of trunk	<input type="checkbox"/> Front paws	<input type="checkbox"/> Back paws
<input type="checkbox"/> Abdomen/stomach	Other _____		

Severity of itch/irritation(circle):(rare/normal) 0 1 2 3 4 5 6 7 8 9 10 (severe)

If there is a rash or lesions on skin/ears, did ITCH start before rash? Did RASH start before itch? (circle)

Is itch present 12 months of the year? YES or NO . If no, what months does your pet itch? _____

Is itch worse INDOORS or OUTDOORS or NO DIFFERENCE? How much time does your pet spend outdoors in terms of percentage of the day? _____

Is there hair loss? YES or NO. If Yes, Where? _____

Is hair loss from scratching? YES or NO or JUST FALLS OUT Does hair grow back? YES or NO

What does your pet eat? Current food: _____

Treats/snacks: _____ Previous diets fed: _____

How do you give your pets oral medications? _____

Pet's appetite NORMAL, INCREASED, or DECREASED Pet's activity level NORMAL or DECREASED

List medical problems other than skin disease _____

List any and all previous adverse reaction(s) to medications or other treatments _____

Have Steroids been used for treatment of this condition (or other condition)? YES or NO

Name	Dose	Frequency	Route	Duration	Does it help (% improved)
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1. _____

2. _____

3. _____

Date and name of last steroid administration (oral, injection, skin or ears) or current _____

Have Antibiotics or Antifungals been used for treatment of this condition? YES or NO

Name	Dose	Frequency	Duration	Does it help? (% improved)
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1. _____

2. _____

3. _____

Date and name of last antibiotic or antifungal administration or current _____

Have Antihistamines been used for treatment of this condition? YES or NO

Name	Dose	Frequency	Duration	Does it help? (% improved)
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1. _____

2. _____

3. _____

Date and name of last Antihistamine given or current _____

Have Fatty acids been uses or given? YES or NO

Name	Dose	Frequency	Duration	Does it help? (% improved)
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1. _____

2. _____

Date and name of last **fatty acid** given or current _____

Other Vitamins or Supplements _____

What medications or and/or cleaners are or have been put into the **ear canals**?

1. _____

2. _____

3. _____

How often is your pet bathed? _____ When was last bath? _____ Groomer? YES or NO

List shampoos and/or conditioners, sprays, wipes, creams etc., used now or in past and frequency

1. _____

2. _____

3. _____

Flea control products used _____ How often _____ Year round? YES or NO

Heartworm prevention used _____ How often _____ Year round? YES or NO

• County Animal Clinic
Yonkers, NY

• Hudson Highlands Veterinary Specialty
Group, Hopewell Junction, NY

• Norwalk Veterinary Hospital
S. Norwalk, CT

• Shoreline Veterinary Referral and
Emergency Center, Shelton, CT

• Katonah Bedford Veterinary Center
Bedford Hills, NY

• Veterinary Referral and Emergency Center
Norwalk, CT

• New Haven Central Hospital for Veterinary
Medicine, New Haven, CT

• Newtown Veterinary Specialists
Newtown, CT