Welcome to the Veterinary Dermatology Specialists!

Please complete the questionnaire below, it helps us help your pet.

VETERINARY DERMATOLOGY SPECIALISTS
ALLERGY · SKIN · EARS

DERMATOLOGY HISTORY

Name of owner: _____ Name of pet:_____

Species and breed of pet:_____ Age of pet: _____

What is the main reason for your visit?_____

How long have you owned this pet? _____ How long has your pet had this problem?_____

Is this the first time your pet has had a skin/ear/nail problem? Yes /No

If no, when was the first occurrence? _____

Itch

Is your pet itchy? Yes/No

If you answered yes, does your pet scratch, lick chew or rub any of the following areas? Please tick all that apply:

__ Nose __ Back __Front legs __Tail

__Ears __ Neck __ Front paws __Chest

__Around eyes __ Groin __ Back legs __ Other: Describe_____

__Abdomen __ Rump __ Back paws

Is this problem seasonal or year-round? Yes/No/Unknown

If you answer YES to being seasonal, which seasons? Spring Summer Autumn Winter

Percentage time spent indoors? ____%

Are symptoms any worse when __ indoors __ outdoors or during the __ morning __ night

Are there any other pets in the household? Yes/No If YES, include species?_____

Any other animals in the household affected? Yes/No

Are any humans in the household affected? Yes/No

What area of the body was first involved? _____

What area of the body was involved next (if any)? _____

How did the involved skin change as time went on? _____

Do any of the parents or siblings have a skin issues Yes/No/Unknown

Ears

1. Does your pet shake its head frequently? Yes/No
2. Is there discharge coming from the ears? Yes/No
3. Is there odour coming from the ears? Yes/No
4. Is there hearing loss? Yes/No

Medications

Is your pet taking any medications currently? _____

What medications has your pet received in the past for this issue? _____

Which medications seem to help? _____

Has your pet had any adverse drug or vaccination reactions before Yes/No.

If YES, describe:_____

Do you use routine flea control for your pet? Yes/no Brand:_____

How often do you bathe your pet?_____ Brand of shampoo/conditioner_____

Diet

List all current diets, and include treats and supplements: _____

_____

Has your pet been on a food trial? No Yes Unknown

How many bowel movements does your pet have per day? _____

General Health

Has your pet had any previous illness, surgery or trauma: Describe_____

Does your pet do exhibit any of the following?

__ Vomiting __ Sneezing __ Runny eyes

__ Diarrhoea __Coughing __ Scooting on their bottom

__ Drinking excessively __ Urinating excessively __ Behaviour changes

Other comments:

_____

_____

_____

Thankyou for completing the questionnaire. We're excited to help you and your pet.

Our family- caring for yours

-The Veterinary Dermatology Specialists

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