**Dr. Kevin Byrne, DVM, MS**
**Diplomate American College of Veterinary Dermatology**
**Patient History Form**

Your name:_____ Date:
Your pet's name:_____
Your pet's age:_____ List any drug allergies: _____
Breed:_____ Gender:____

*This information will help us help your pet.*

1. What are your pet's problems *currently*: (check all that apply)

Hair loss ( )
Scratching, chewing, licking, rubbing, skin ( )
Red bumps, pimples, scabs ( )
Ear infections ( )
Skin infections ( )
Excessive dandruff, scaling ( )
Skin odor ( )
Nail infections or nail loss ( )
Other (describe) ( ) _____

2. *How long* has/have the current problem(s) been present? _____

3. What did your pet's problems look like *initially*? _____

4. What areas of your pet are affected? (check all that apply)
Ears ( ); Face ( ); Neck ( ); Armpits ( ); Rump/tail area ( ); Underside ( );
Groin/inner thighs ( ); Legs/paws ( ); Anal/genital area ( ); Other_____

5. What treatment has your pet received for his/her skin problem? Check all that apply and list or circle names if possible:

( ) Antibiotics (list if you know) _____

( ) Oral cortisone e.g.: prednisone, Vetalog, dexamethasone
( ) Cortisone/steroid injections
( ) Antihistamines e.g.: Benadryl, Atarax, chlorpheniramine
( ) Fatty acids/oils, fish oil capsules, vegetable oils
( ) Ivermectin (anti-mite) injection(s)
( ) Ear ointments or drops (list if you know) _____
( ) Herbal or homeopathic remedies (list if you know) _____
( ) Allergy vaccines: based on skin test: __ or blood test: __

6. Did medication/therapy help your pet's problem(s)? Yes( ) No( ) If no, go to 7
If yes, which medication was the *most* effective?_____
Did the lesions resolve with this medication/therapy? Yes( ) No( ) Did the lesions return after medication/therapy was stopped? Yes( ) No( ) How long did it take for the lesions to return?_____ (weeks/months)(circle)

7. On a scale of 1-10 with 1 = occasional chewing or scratching and 10 = severe, constant scratching that keeps you up at night, how would you rate your pet's level of itchiness <u>now</u>? (circle number from 0-10): 0 1 2 3 4 5 6 7 8 9 10.
How would you rate chewing or scratching while your pet was on antibiotics and nothing else?____/10. Or, my pet was never on antibiotics alone: __

8. Is there *currently* a relationship between your pet's problem(s) and the season of the year? Yes ( ) No ( ) If yes, please check the season(s) when the problem is worse: Spring ( ); Summer ( ); Fall ( ); Winter ( )
*In the past* was there a relationship between your your pet's problem(s) and the season of the year? Yes ( ) No ( ) If yes, what seasons? _____

9. Do you have any other pets? Yes ( ); No ( ); Please list any other pets _____

10. Do your other pets have any skin problems? Yes ( ); No ( ); Does not apply ( ) If yes, what are the other pet's problems? _____

11. Describe the indoor environment of your pet – such as bedding, where he/she sleeps, etc. _____

12. Describe the outdoor environment (grasses, weeds, trees, wooded areas, etc…) _____
How many hours of the day is your pet outdoors?_____

13. Have you noticed fleas on your pet recently? Yes ( ); No ( )

14. What flea products do you currently use? _____

15. Has any person in your household had skin problems since your pet started having skin problems? Yes ( ); No ( ) If yes, please describe _____

16. What oral or injectable medication is your pet presently receiving and when was it last given? _____

17. What shampoos, sprays, creams, ointments, lotions are your pet presently receiving? _____
What ear medications and cleansers is your pet presently receiving?
_____

18. Which food is your pet currently receiving? _____How long? _____

19. Does your pet receive anything else to eat? E.g. table food, treats, biscuits, vitamin supplements, or rawhide chews given? Please list _____
_____

20. Does your pet have any other medical or surgical problems unrelated to the skin disorder? Yes ( ); No ( ) Please describe:
_____
Is your pet receiving any medication for this disorder? Please list medications:
_____

21. Are there any changes in food or water intake, changes in urination or defecation, changes in activity level?
Yes ( ) No ( ) Please list: _____

22. Has your pet ever been on a special food elimination diet? Yes ( ); No ( ); If yes, what brand of food or home-cooked diet ingredients were used and for how long? _____

Were treats, table food, biscuits, rawhides, or chewable medications given while on the diet? Yes ( ); No ( )

23. For dogs: Is your pet currently on heartworm prevention? Yes ( ); No ( ) If yes, is it a chewable? Yes ( ); No ( )

24. For cats: Was your pet tested for feline leukemia virus (FeLV)? Yes( ) No( )

25. Has your pet always lived in this part of the country? Yes ( ) No ( )