



Dermatology

History



Reason for today's visit:

_____ (please continue on reverse if needed).

When did the problem begin; describe progression: _____

What areas of the body are affected? _____

How is your pet for examinations? _____

Please describe any past illnesses: _____

Mark any *current* symptoms: coughing sneezing vomiting diarrhea not eating well weight loss
 weight gain excessive drinking excessive urination fatigue lethargy eye discharge behavioral change
 other: _____

List other animals your pet has contact with: _____

Is your pet currently on flea/tick preventative? List type and frequency: _____

Do any humans in the home have skin problems? _____

How itchy is your pet? mild moderate severe

What symptoms do they have? scratching rubbing licking biting

The problem is: year round seasonally unknown When is it the worst? spring summer fall winter

Ear symptoms? foul smell discharge scratching right ear scratching left ear head shaking

Ear Medications: _____

Diet: Food usually fed (brand) _____ canned semi-moist dry

Is your pet on any supplements? _____

Has your pet had a food trial? Yes No Length of trial? _____

Which foods were in the trial? _____

Has your cat eaten anything other than the food listed above (including people food, treats)? no yes, describe: _____

How frequently do you bathe and with what? _____

List any known food or drug sensitivity: _____

Is your pet on any medications? no yes _____ prescription over the counter

Please list current and past drugs. Indicate if they helped the problem:

