PATIENT HISTORY FORM- NEW PATIENT

Northeast Veterinary Dermatology Specialists
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Patient Name ________________________

Date: _____________

Primary concern/presenting problem: ____

Age of pet when skin problem started:__________________**Duration of problem**___________________

What was the first thing you noted when problem started (ie itching, rash, red skin, scale, crust, etc.):

Where on the body did the problem start (circle)

Nose	Top of back	Back legs
Around eyes	Rump	Front paws
Mouth/muzzle	Sides of trunk	Back paws
Ears/ear flaps	Tail	Chest
Abdomen/stomach/groin	Under tail	Nails
Neck	Front legs	Other

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

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

Nose	Top of back	Back legs
Around eyes	Rump	Front paws
Mouth/muzzle	Sides of trunk	Back paws
Ears/ear flaps	Tail	Chest
Abdomen/stomach/groin	Under tail	Nails
Neck	Front legs	Other

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

IF there is a rash also, did **ITCH start before rash**? OR Did **RASH start before itch**? (circle)

Is itch present 12 months of the year? (ie is the itch a year round problem?) YES or NO
If no, what months does your pet itch? ______________________
Is itch worse **indoors** or **outdoors** or **no difference** (circle)
How much time does your pet spend outdoors? ____%

Is there hair loss? YES or NO **Does the hair grow back**? YES or NO
Where is hair loss? ____

DIET: **What does your dog eat**?

1. Dog food: ____
2. Treats/snacks: ____
3. Previous diets fed: ____

Is your pet's appetite NORMAL, INCREASED, or DECREASED (Circle)

Is your pet's activity level NORMAL, DECREASED (circle)

Does your pet do any of the following on a regular basis? (Circle)

Cough	Urinate in excess	Limp
Sneeze	Vomit	Pant in excess
Drink water in excess	Diarrhea	Other:______________

Does your pet have any **other medical problems** other than skin disease?______________________________

Treatments **that have not helped** this condition

____

Treatments that **have helped** the condition: ____

Have **steroids** been used? YES or NO

Name	Dose	Frequency	Route	Duration	**Did it work (% improved)**
1.					
2.					
3.					

When were **steroids last given** and in **what form** including on skin or in ears? __________________________

Antibiotics that have been given (if any):

Name	Dose	Frequency	Duration	**Did it work (% improved)**
1.				
2.				
3.				

Date of last antibiotic administration and name of antibiotic:______________________________________

Flea control products used: ______________________ How often: ______________ Year round? YES or NO

Heartworm prevention used: _____________________How often: ______________ Year round? YES or NO

Vitamins or Supplements: ____

How often is your pet bathed? ______________________________ **When was the last bath**? ____________

What shampoos and/or conditioners are used when bathed _______________________________________

Other topical products (sprays, wipes, conditioners, creams etc.) applied to the skin & frequency
____

Medications/cleaners put into the **ear canals**____

How do you give your pets oral medications?

____

Other pets/animals in the household: ____

Are any other 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