

Dermatology Pet Questionnaire

Date: _____ Last Name: _____ Patient: _____

Please answer the questions to the best of your ability. The doctor will go over these questions with you in the exam room.

Primary reason for referral? _____

Other pets in the household? **Yes** **No**
If yes, indicate the number and species: _____

Vaccine history:

Is your pet up to date on vaccines? **Yes** **No**

Flea/Tick control: Please circle the flea/tick preventative your pet is on.

FRONTLINE	FRONTLINE SPRAY	ADVANTAGE	ADVANTIX
REVOLUTION	SENTINEL	PROGRAM	COMFORTIS
VECTRA	PROMERIS	OTHER: _____	

Please indicate how often the flea/tick product is applied? _____

Are your other pets on flea/tick prevention? **Yes** **No**

Have you had a recent tick and/or flea problem? **Yes** **No**

Heartworm control: What heartworm control is your pet currently on?

HEARTGUARD	INTERCEPTOR	SENTINEL	REVOLUTION
OTHER: _____			

Diet:

What is your pet's current diet? _____

List all the treats your pet eats: _____

Has your pet ever been on a food trial or hypoallergenic diet? If so, which one?

Last name: _____ Patient: _____

Questions referring to dermatological problem:

When did the problem start (age, apprx date, time of year)? _____

Did the problem have a gradual onset or sudden onset? _____

Where is your pet itchy (Itchiness also equals: rubbing, chewing, scratching, licking, over-grooming)?

FACE	EARS	MUZZLE	EYES	NECK	BACK	GROIN
PAWS	REAR LEGS	FRONT LEGS	TAIL	UNDERARM	ABDOMEN	

OTHER: _____

Please grade your pet's itchiness on scale of 1-10 (with 1 meaning occasional scratching and 10 meaning constant severe scratching)? _____

Is itchiness more in front half or back half of body? _____

Is the problem worse during certain times of the year? If so, when? _____

Any ear infections and/or itchiness currently or in past? _____

Are there other pets affected?	Yes	No
Are there humans affected?	Yes	No
Has your pet ever been skin allergy or blood allergy tested?	Yes	No
Has your pet ever been on allergy vaccines?	Yes	No

USE THE SECTION BELOW TO SUMMARIZE YOUR PET'S PROBLEM/CONCERNS OR ANY ADDITIONAL INFORMATION FOR THE DR TO KNOW:

Last name: _____ **Patient:** _____

Medications:

Has your pet received steroids (cortisone or “allergy shots”)?	Yes	No
If yes, did your pet get better with steroids?	Yes	No
Is/Has your pet been on antibiotics?	Yes	No
Is/Has your pet been on antifungal medication?	Yes	No
Is/Has your pet been on topical therapy (i.e. shampoos, sprays, creams, lotions etc) for its skin?	Yes	No
Is/Has your pet been on antihistamines (i.e. Benadryl)?	Yes	No
Is/Has your pet been on fatty acids (i.e. fish oils)?	Yes	No
Is/Has your pet been on topical ear medications?	Yes	No
Is/Has your pet ever been on ATOPICA (cyclosporine)?	Yes	No

Please list any other medications your pet is currently on (this includes, vitamins, herbal meds, arthritis medication)?

To your knowledge, does your pet have any adverse reactions to any medications?

If yes, please list medication(s)? _____

Do not need to answer: Any persons in the household are diabetic, have breathing problems (asthma), on medications for Parkinson’s disease or immunosuppressed (on chemotherapy, HIV, high doses of steroids)?

Doctor may need to know this if she decides to prescribe certain medications for your pet or is suspicious of certain disease with your pet.

Additional notes: _____
