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? _____

When did the problem start (i.e. years, months, days or weeks ago)? _____

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 a scale of 1-10 (with 1 meaning occasional scratching and 10 meaning constant severe scratching)? _____

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

_____

Besides your pet being itchy do you think your pet is painful with its skin or ear problem? (Pain signs may be obvious like vocalizing, crying when skin or ear is touched but sometimes it's more like a change in personality like quieter than usual, not as playful, to themselves or even aggressive.) **Yes** **No**

If yes, please grade your pet's pain level on a scale of 1-5 (with 1 meaning no signs of pain and 5 meaning significant
pain)_____

Is the skin or ear problem worse during certain times of the year? If so, when?

_____

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

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

_____

Are there other pets affected? **Yes** **No**

Are there humans affected? **Yes** **No**

Last name: _____ Patient: _____

Has your pet ever been skin allergy or blood allergy tested? **Yes** **No**

Has your pet ever been on allergy vaccines? **Yes** **No**

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**

Is/Has your pet ever been on APOQUEL? **Yes** **No**

Is/Has your pet ever been on CYTOPOINT injection? **Yes** **No**

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

COMFORTIS NEXGARD BRAVECTO SENTINEL TRIFEXIS
SIMPARICA 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 flea and/or tick problem? **Yes** **No**

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

Last name: _____ Patient: _____

Diet:

What brand of food is your pet eating?

_____

List all brands of food your pet has previously eaten:

_____

List all the treats your pet eats: _____

_____

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

_____

_____

Environment:

Is your pet: INDOOR OUTDOOR BOTH

Are your other pets? INDOOR OUTDOOR BOTH

Please describe your home:

APARTMENT HOUSE CONDO TOWNHOUSE

MOBILE HOME Other _____

Has your pet lived in Florida all its life? **Yes** **No**

Has your pet lived or traveled outside of the country? **Yes** **No**

If yes, when, where and length of time? _____

_____

Other:

Does your pet have normal bowel movements (defecations)? **Yes** **No**

How often does your pet defecate? _____

How much water do you think your pet drinks? (circle one)

Normal amount More than normal Less than normal

How often does your pet urinate? (circle one)

Normal frequency More frequent than usual Less frequent than usual

Any vomiting/diarrhea episodes currently or in the past? (circle one) **Yes** **No**

If yes, is this a current problem? _____

_____

Has your pet been diagnosed with epilepsy or has your pet had seizures in the past? _____

Last name: _____ Patient: _____

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)? _____
_____

FOR CLIENTS BRINGING IN A CAT:
Has your cat been tested for feline leukemia or feline immunodeficiency virus? **Yes** **No**
Results:

_____
_____

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

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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