



DERMATOLOGY QUESTIONNAIRE

PART "D"

If you do not know the answer to a question or do not understand the question please
leave the answer blank DO NOT guess

A) GENERAL

Owner Name:

Phone:

Clients Name:

Email:

Pet Name:

Breed:

Age:

Sex: M F M/N F/S

- 1.) Age or Date when you Acquired Pet:
- 2.) Where was your pet obtained: Breeder Pet store Private sale
 Humane Society Stray Other:

B) SYMPTOMS

- 1.) Describe the current skin problem(s)
Rash Hairloss Itching Smelly Other:
- 2.) Approximate Date when problem FIRST started:
Onset: Sudden or Gradual
- 3.) Are Symptoms getting worse: Yes No
- 4.) When did it start to get worse:
- 5.) Where on your pets body did the problem FIRST begin, check all that apply:
Muzzle Eyes Ears Neck Back
Tail Rump Armpits Front Legs Back legs
Thighs Front Paws Back Paws Chest Abdomen
Groin Other:
- 6.) What did the problem look like *initially*:
Normal Skin, just "itch" Pimples
Hair Loss Redness
Rash Other:
- 7.) Has problem changed or spread: Yes No
If so when/where:
- 8.) Have the ears been involved ie: infected, waxy +/- itchy: Yes No

C) SYSTEMIC (General Health)

- 1.) Any changes in weight: Yes No
If yes weight loss or weight Gain
- 2.) Any decrease in activity levels: Yes No
- 3.) Any increase in drinking: Yes No
- 4.) Any increase in urinating: Yes No

- 5.) Any increase in appetite: Yes No
- 6.) Any other medical/health conditions or illness:

D.) CONTAGION

- 1.) Do you have any other pets in the household: Yes No
If yes please list:
- 2.) Do they have any skin problems: Yes No
If yes please describe:
- 3.) Do any people in the household have skin problems: Yes No
If yes please describe:
- 4.) Does your dog go to doggy daycare, groomers, dog parks etc. Yes No
If yes please describe how often:

E) DRUG HISTORY (check all that apply)

	When	Did it help?	When was it stopped?
Antihistamines (ie: Benadryl...)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cortisone (ie: prednisone, VanectylP)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cortisone Injections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Atopica/Neoral (Cyclosporine)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Antibiotics	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
-what kind=			
Shampoo	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
-what kind=			
Flea Control	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
-what kind=			
Any fleas seen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ear Meds			
-which ones/when			
Eye Meds			
-which ones/when			
Topical Meds			
-which ones/when			
Were there any adverse reactions to any of the above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, what were the symptoms?	Vomiting <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	
	Skin got worse <input type="checkbox"/>	Severe Itching <input type="checkbox"/>	
	Other		

F) FOOD HISTORY

- 1.) List pet foods, treats (cookies, biscuits, chews, snacks etc) and human food: