

Welcome to the Veterinary Dermatology Specialists!

Please complete the questionnaire below, it helps us help your pet.



DERMATOLOGY HISTORY

Name of owner: _____ Name of pet: _____

Species and breed of pet: _____ Age of pet: _____

What is the main reason for your visit? _____

How long have you owned this pet? _____ How long has your pet had this problem? _____

Is this the first time your pet has had a skin/ear/nail problem? Yes /No

If no, when was the first occurrence? _____

Itch

Is your pet itchy? Yes/No

If you answered yes, does your pet scratch, lick chew or rub any of the following areas? Please tick all that apply:

- | | | | |
|--------------------------------------|--------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Nose | <input type="checkbox"/> Back | <input type="checkbox"/> Front legs | <input type="checkbox"/> Tail |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Neck | <input type="checkbox"/> Front paws | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Around eyes | <input type="checkbox"/> Groin | <input type="checkbox"/> Back legs | <input type="checkbox"/> Other: Describe _____ |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Rump | <input type="checkbox"/> Back paws | |

Is this problem seasonal or year-round? Yes/No/Unknown

If you answer YES to being seasonal, which seasons? Spring Summer Autumn Winter

Percentage time spent indoors? _____%

Are symptoms any worse when indoors outdoors or during the morning night

Are there any other pets in the household? Yes/No If YES, include species? _____

Any other animals in the household affected? Yes/No

Are any humans in the household affected? Yes/No

Do any of the parents or siblings have a skin issues Yes/No/Unknown

Ears

- | | |
|--|--|
| 1. Does your pet shake its head frequently? Yes/No | 3. Is there odour coming from the ears? Yes/No |
| 2. Is there discharge coming from the ears? Yes/No | 4. Is there hearing loss? Yes/No |

Medications

Is your pet taking any medications currently? _____

What medications has your pet received in the past for this issue? _____

Which medications seem to help? _____

Has your pet had any adverse drug or vaccination reactions before Yes/No.

If YES, describe: _____

Do you use routine flea control for your pet? Yes/no Brand: _____

How often do you bathe your pet? _____ Brand of shampoo/conditioner _____

Diet

List all current diets, and include treats and supplements: _____

Has your pet been on a food trial? No Yes Unknown

How many bowel movements does your pet have per day? _____

General Health

Has your pet had any previous illness, surgery or trauma: Describe _____

Does your pet do exhibit any of the following?

Vomiting Sneezing Runny eyes

Diarrhoea Coughing Scooting on their bottom

Drinking excessively Urinating excessively Behaviour changes

Other comments:

Can we take photos of your pet and use the images on our social media, website or for teaching? Yes/No

Please follow us on Social Media and tag us #vetdermspecialists

Instagram: @vetdermspecialists

Facebook: @VetDermSpecialists

Do you or your pet have an Instagram account we can follow? Insert Instagram/Facebook account names here: _____

Thankyou for completing the questionnaire. We're excited to help you and your pet.

Our family- caring for yours

-The Veterinary Dermatology Specialists

