Silver Spring Animal Hospital
1915 Seminary Road
Silver Spring, MD 20910
Phone: 301-587-6099
Fax: 301-587-2007

Today's Date: _____
Client Name: _____
Pet Name: _____
Pet's Age: _____
Appointment Date: _____
Appointment Time: _____

Dermatology History

To help us better understand your pet's problem(s), please complete this questionnaire as best as possible.

Describe your pet's dermatological (skin/ear) problem(s):
When did the problem(s) first appear?
Was the onset: ___ Gradual ___ Sudden
Where on the body did you first notice the problem(s)? ___ Face ___ Ears ___ Rump ___ Tail ___ Chest ___ Limbs ___ Paws ___ Abdomen ___ Back ___ Other
Was 'itching' the first sign you noticed?
If your pet is itching, please indicate the frequency: ___ Sporadic ___ Constant
Does your pet excessively: ___ Lick ___ Chew ___ Bite ___ Rub ___ Scratch ___ Scoot ___ Shake Head
Is the problem seasonal? ___ Yes ___ No If yes, please indicate the occurrence: ___ Spring ___ Summer ___ Fall ___ Winter
Has your pet ever had ear problems? ___ Yes ___ No If yes, please explain:
Have you noticed fleas on your pet? ___ Yes ___ No
What percentage of time does pet spend outdoors _____ and indoors _____?
Is the problem worse: ___ Indoors ___ Outdoors ___ No noticeable difference
Please list any other animals in your pet's immediate environment (your own, neighbors', wildlife, pet park, etc.): Have you noticed similar skin problems affecting these animals? ___ Yes ___ No
Have any people or other animals in your household developed skin problems? ___ Yes ___ No

Describe your pet's indoor environment.

Bedding:
Carpets:
Flooring:

Describe your pet's outdoor environment.

Trees:
Grasses:
Weeds:
Other:

Describe your pet's diet.

Pet food (brand, dry/canned, etc.):
Snack / Treats:
Table food:
Supplements:

Have there been any changes in your pet's diet? ___ Yes ___ No
If yes, was your pet's dermatological (skin/ear) problem affected by the dietary change(s)? ___ Yes ___ No

Has your pet been prescribed any of the following treatments for its dermatological problem? If yes, please indicate your pet's **response** to the treatment and the date **last given** to your pet.

Steroids (e.g., prednisone, Temaril-P, Depo-Medrol, Vetalog):
Antihistamines (e.g., Benadryl, hydroxyzine, chlorpheniramine):
Antibiotics (e.g., Baytril, cephalexin, Clavamox, Simplicef):
Fatty acids:
Ear medication:
Flea/tick preventative (name):
Topicals (e.g., shampoos, sprays):
Home remedies / Other treatments:

Does your pet have any known adverse/allergic reactions to foods or medications (e.g., antibiotics, vaccines, shampoos, etc.)?
Please explain:

Client Signature: _____

Print Name: _____

Date: _____