



VCA San Francisco Veterinary Specialists Dermatology Patient History

Today's date: _____ Your name: _____ Pet's name: _____

Chief complaint(s): _____

Age of pet when acquired: _____ Pet's current age: _____ Approximate date problem started: _____

Is your pet: Intact Altered If altered, at what age? _____

Is condition: Seasonal Continuous If problem is now continuous, was it initially seasonal? Yes No

Is there a time when the disease is: Less severe Itching is less intense? When? _____

Percent of time pet is kept: Indoors _____% Outdoors _____%

Are symptoms worse: Indoors Outdoors Morning Night Describe: _____

What was the problem like initially? Normal skin, but itchy Hair loss Rash Pimples Redness

Where did the problem start? Nose Ears Neck Back Rump Tail

Front legs Front paws Back paws Back legs Eyes Chest Abdomen Groin

Has it spread? Yes No If so, where? _____

Does your pet scratch, rub, chew, lick or bite any of the following areas? Nose Muzzle Eyes

Back paws Chest Back Front legs Rump Tail Abdomen

Back legs Ears Neck Front paws Armpits Groin Inner thighs and legs

How itchy is your pet on a scale of 1 to 10 (with 10 being the worst possible)? _____ Comments: _____

Does your pet do/have any of the following? If yes, list frequency and description:

Cough Yes No _____ Sneeze Yes No _____

Runny eyes Yes No _____ Ear infections Yes No _____

Diarrhea Yes No _____ Vomit Yes No _____

Loss of appetite Yes No _____ Drink excessively Yes No _____

Urinate excessively Yes No _____ Limp Yes No _____

Do you have other pets? Yes No List species: _____

If you have other pets, are they affected? Yes No Describe: _____

Do you or anyone else in your household have skin problems? Yes No Describe: _____

Do your pet's littermates or parents have skin problems? Yes No Comments: _____

If yes, explain: _____

Do you use flea control on your pet? Yes No Type: _____ How often? _____

Do you use environmental flea control in your home and/or yard? Yes No Frequency: _____

Please list medications/injections your pet has taken for the skin condition: _____

Other medications your pet is receiving: _____

Did any medications help the problem? Yes No Which one(s)? _____

Please list any vitamins, food supplements, etc., your pet has been given: _____

How often do you bathe your pet and what shampoos are used? _____

What is your pet's current diet, including treats? _____

How long has your pet been on this diet? _____

Please circle the number of bowel movements your pet has per day: 1 2 3 4 5 6

Has your pet received treatment for stomach or intestinal problems? Yes No If yes, explain: _____

Please circle how many times your pet was treated for this skin condition prior to visiting SFVS: 1 2 3 4 5 6

Additional comments: _____