



Patient History Form

Primary reason for visit (please be more specific than skin/allergies):

Where was your pet acquired: _____ Age acquired: _____

Age when problem started: _____ What was the problem initially? Hair loss _____

Rash _____ Redness _____ Normal skin/Itchy _____ Other: _____

Describe:

Is the problem Seasonal or Year round? _____ Does problem go away and return? _____

Where did the problem start?: _____

Has it spread? _____ Where?: _____

Current medications:

What medications and/or treatments helped for this problem(s)?

Do you have other pets? #Cats _____ #Dogs _____ #Other _____

Do your other pets have skin problems recently? _____

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

Are symptoms worse in: AM _____ PM _____ Overnight _____

Explain:

What do you use for Flea Control? _____ Date last applied: _____

How often is pet bathed? _____

Product(s) used for baths or topically:

What diet does your pet eat? _____ How long on this diet? _____

Does your pet have any other health concerns?

Pet Name: _____ Owner Name: _____ Date: _____