NEW PATIENT FORM

Please fill out this form to the best of your ability. A complete history is very important in diagnosing and managing allergies, ear, and skin disease.
If you are unsure of how to respond to a question, please ask. Our goal is to use the information you provide in this questionnaire and during the office visit to increase our efficiency and to help ensure the best possible treatment for your pet.

Date: _____

CLIENT INFORMATION

Name: _____
Spouse/Other Owner (if applicable): _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
☐ Home Telephone: _____ ☐ Work Telephone: _____

☐ Spouse/Other Telephone: _____ ☐ Cell Phone: _____

To avoid not being able to reach you when we return your call, please place a checkmark beside the best number to reach you during the day

E-mail Address: _____

Referral Information:
We prefer, but do not require, a referral from your primary care veterinarian. However, we do require that you have an established relationship with a primary care veterinarian for emergencies and for conditions other than those that affect the skin and ears. We will contact your primary care veterinarian by referral letter to inform them that you have been seen by us.

Contact Information for Primary care veterinarian: Referral: ☐ Yes ☐ No
Name of Doctor: _____
Name of Hospital: _____
Address: _____
_____

Phone number: _____
Fax number: _____

If you have seen other veterinarians for your pet's skin condition over the past year, you should have copies of their records sent to us in addition to those from your current veterinarian.

PAYMENT OPTIONS

All bills must be paid when services are rendered. We accept all major credit cards.
Personal checks are welcome when accompanied by a driver's license. We do not bill. If you have any questions regarding your payment today, please discuss it with a receptionist before seeing the doctor.
Thank you.

PATIENT INFORMATION
(Please fill in blanks or circle where applicable)

1. Name: Species: Canine Feline Other Breed:

2. Sex: Male Neutered Male Female Spayed Female

If applicable, when was the last heat cycle?

3. Date of Birth: 4. Color/Markings:

5. Are you this pet's owner? Yes No At what approximate age did you obtain this pet?

6. Where did you obtain this pet?

Breeder (Large kennel or backyard/hobby) Shelter Pet Shop Other

7. Has this pet ever lived/visited outside your current geographical area? Yes No

8. What percentage of the time does your pet spend indoors or outdoors? %Indoors %Outdoors

9. Does your pet go to:

a. Boarding kennel Yes No If yes, how often?

b. Groomers Yes No If yes, how often?

10. Please briefly list any known health problems other than skin/ear disease:

11. Please list any medications given to this pet for problems **OTHER** than the skin disease:

12. Describe what your pet sleeps on (pet's bed, owner's bed, feather bed, wool, outdoors, etc):

PATIENT HISTORY

1. *What is the primary reason for today's visit?*

2. *Does your pet experience any of the following?*

Vomiting How often?
Diarrhea How often?
Constipation How often?

Coughing How often?
Sneezing How often?
Lameness How often? **OVER**

Weight: Maintained Increased Decreased Comment:

Urination: Normal Increased Decreased Comment:

Drinking Behavior: Normal Increased Decreased Comment:

Appetite: Normal Increased Decreased Comment:

Activity level: Normal Increased Decreased Comment:

3. *Please check any of the following clinical signs that pertain to your pet:*

☐ Itching/Scratching/ Licking/Chewing ☐ Ear infections ☐ Excessive Flaky Skin (Dandruff)
☐ Red Skin ☐ Skin odor/greasiness ☐ Bumps, pimples, scabs ☐ Welts (Hives/Wheals)
☐ Hair loss **with** itching ☐ Hair Loss **without** itching (Alopecia)
☐ Curving /Cracking /Breaking Nails / Loss of Nails/Nail infections
☐ Swollen Feet (Between Toes)
☐ Draining lumps
☐ Other (describe): _____

4. *Age when the problem was initially noticed*:

5. *Onset of disease / lesions* : gradual sudden

6. *Where do the lesions start* : back belly groin armpits feet ears face

7. *What did the lesions initially look like?*

8. *Has the problem ever gone away completely since it started?*

9**.** *Which would you say best describes the progression of your pet's skin problem?*

☐ I first noticed a skin rash or hair loss which does not seem to bother my pet

☐ I first noticed a skin rash or hair loss and afterwards some itching developed (chewing, biting, scratching, rubbing or licking)

☐ I first noticed some itching (chewing, biting, scratching, rubbing or licking) before any hair loss/rash

10. *If your pet is itchy* (chewing, biting, scratching, rubbing or licking), *please answer the following questions:*

a. *On a scale of 1 – 10, how severe is the itching?*
(1=slight, 10=severe/ constant, keeps you wake at night, stops normal activities to itch) 0 1 2 3 4 5 6 7 8 9 10

b. *How frequent is the itching:* Rare Sporadic Constant

c. *When is the itching the worst?* Always Daytime Evening

d. *Is the problem worse:* indoors outdoors doesn't seem to matter

e. *Where does your pet itch?* (you may circle more than one)

lower back/rump/tail feet legs face ears underside armpits/chest groin/inner thighs

anal/genital area all over other-specify **OVER**

11. *Is the problem year-round?* (nonseasonal)

☐ yes, it has always been year round
☐ yes, but it used to be seasonal (only part of the year)
☐ No (see question 12)
☐ Unknown

12. *If seasonal, which time of year is the problem present or more severe* (you may circle more than one season)

Spring Summer Fall Winter

13. a. *Do you own other pets?* Yes No If yes, what kind?

Indoors Outdoors

b. *Is there exposure to other animals outside your household?* Yes No

If yes, what kind?

c. *Do other animals or people in the house have lesions/itching?* Yes No

If yes, who?

14. *Do you know if any litter mates or the parents of this pet have similar skin problems?*
Yes No Unknown

Routine Care:

1. *Is your pet up to date on vaccinations?*

2. *When was the approximate date of this pet's last vaccines?* *How often does your pet receive vaccines?*

3. ***For Dogs:***
a. *Is your pet receiving heartworm prevention:* Yes No Don't know

b. *Which brand?* Heartgard® Interceptor® Sentinel® Revolution®-topical

c. *Has your pet been tested for heartworm disease in the past 12 months?* Yes No Don't know

4. ***For Cats:***
a. *Has your pet been tested negative for Feline leukemia virus (FeLv) and Feline immunodeficiency virus (FIV or Feline Aids)?* Yes No Don't know When was the last test done?

5. **Flea and/or Tick Prevention**:
a. *Do you routinely use flea and tick control?* Yes No Don't know
If Yes, Please check which one used:

☐ Advantage® - topical ☐ Frontline® / Frontline Plus® - topical ☐ K9 Advantix® - topical ☐ Revolution® - topical
☐ Hartz® / Biospot /other OTC topical spot on ☐ Program® - oral ☐ Capstar® - oral ☐ Other:

b. *How often is it applied to this pet?* *to other pets in the household?*

c. *Have you ever noticed any Fleas Ticks* On this pet? Yes No Don't know

On other pets or in contact animals? Yes No Don't know **OVER**

6. **Diet:**

a. What is the current diet (i.e., canned, kibble, brand, etc.)?

b. Has a special diet been tried? Yes No Don't know

c. If yes, which diet(s)?

d. Does/Did the diet seem helpful? Yes No Don't know

e. What treats are provided (biscuits, rawhide/pig ears, hooves, bones, table food)?

f. Do you brush your pet's teeth? Yes No Don't know

g. If yes, what flavor is the toothpaste

h. If using an oral medication, is it flavored? Yes No Don't know

i.

j. Is your pet receiving medication for arthritis/joint problems? Yes No Don't know

If yes, which one? (please check)

Nutraceutical joint health supplements such as ☐ Chondroitin Sulfate ☐ Glucosamine – oral

NSAIDS: ☐ Etogesic ® ☐ Rimadyl® ☐ Deramaxx® ☐ Metacam® ☐ other

Are these flavored? Yes ☐ No ☐ Don't know ☐ If yes, list flavor(s) if known

7. Medical Treatments:
a. *Have treatments been tried for skin or ear disease/allergies?* Yes No Don't know

b. *Please check name of medication and indicate:* 1. Dose if known, 2. How long your pet has been receiving treatment and if currently being used. Please leave blank if you do not know, we will fill out at time of appointment.

** Include treatments that are over-the-counter.**

Antihistamines:

☐ Diphenhydramine (Benadryl) ☐ Chlorpheniramine (CPM, Chlortrimeton) ☐ Clemastine (Tavist)
☐ Hydroxyzine (Atarax) ☐ Loratadine (Claritin) ☐ Zyrtec ☐ Allegra

Dose: How long your pet has been receiving treatment?

Currently being used?

Corticosteroids:

☐ Injectable

Oral: ☐ Prednisone/Prednisolone ☐ Dexamethasone ☐ Temaril—P ☐ Other

Dose: How long your pet has been receiving treatment?

Currently being used?

OVER

Atopica (Cyclosporine, Neoral)

Dose: How long your pet has been receiving treatment?

Currently being used?

Antibiotics:

☐ Cephalexin (Keflex) ☐ Cefpodoxime(Simplicef) ☐ Clavamox ☐ Clindamycin

☐ TrimethoprimSulfa ☐ Primor ☐ Enrofloxacin (Baytril) ☐ Marbofloxacin (Zenequin)

☐ Ciprofloxacin ☐ Other

Dose: How long your pet has been receiving treatment?

Currently being used?

Anti-yeast:

☐ Ketoconazole ☐ Itraconazole (Sporonox) ☐ Fluconazole

Dose: How long your pet has been receiving treatment?

Currently being used?

Essential Fatty Acids: List Brand if known

Topical Therapy:

Ear cleaners and/or medications

Topical sprays, lotions, wipes

Ointments/creams

Other (i.e., allergy shots, natural supplements):

8. **BATHING / SWIMMING HISTORY**

a. *Last time bathed:* *Frequency of bathing*:

b. *Product(s) used:*

c. *Bathing location* groomer home self-dog wash

d. Helpful No change Worse

e. Swimming: Yes No Where? River Lake Frequency:

Please provide any other information that you feel may be helpful: