Dermatology Consult

Abegweit Animal Hospital

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To help us better serve you more efficiently, please fill out the following questionnaire and return it to us prior to your appointment. Dr. MacDonald would like to have your information to review before your arrival.

\*\*Important Items to Note\*\*

* If you are unsure of your answer or do not understand the question, leave the answer blank. DO NOT guess
* The terms ITCHY refers to itching, scratching, licking, chewing, biting and rubbing
* Ears and paws are common areas for allergies, please consider these areas when questions are asked about ‘skin’

**General Information**

1. Name:
2. Mailing Address:
3. Phone Numbers:
	1. Cell:
	2. Work:
	3. Home:
4. Pets Name:
5. Pets Breed:
6. Birthday (or approximate age):
7. Sex:[ ] Male [ ] Female Spayed/Neutered:[ ] Yes[ ] No
8. Age or Date when you acquired your pet:
9. Where did you acquire your pet (breeder, Humane Society, etc.):
10. Has your pet moved residence?[ ] Yes [ ] No

If yes, when:

If yes, was it: [ ] Local [ ] Another Province [ ] International

From: To:

1. Please list all species that live on the property:
	1. Does any animal or human have a history of skin problems: [ ] Yes [ ] No
2. Has your pet been previously tested for allergies:[ ] Yes [ ] No

If yes, please forward a copy of the results

1. Has your pet been seen by another Veterinarian: [ ] Yes [ ] No

If yes, please have the medical record forwarded to us

1. Do you have your pet groomed: [ ] Yes [ ] No

If yes, how frequently and what products are used:

1. Do you travel off island with your pet:[ ] Yes [ ] No

If yes, where:

1. Does your pet go to day care: [ ] Yes [ ] No
2. Do you board your pet: [ ] Yes [ ] No

**General Information**

Provide a brief description of symptoms:

1. Approximate date when the problem(s) first started:
2. If the problem has been continuous for over one year, did it start of as seasonal:

[ ] Yes [ ] No [ ] Unsure

1. How itchy is your pet on a scale of 1-10 (10 being the worst possible):
2. Are the symptoms getting worse: [ ] Yes [ ] No

If yes, when did they start to get worse:

1. Is there a time when your pet symptoms subside: [ ] Yes [ ] No

If yes, when:

1. Does your pet ‘ITCH’: [ ] Yes [ ] No

If yes, check all that apply:

[ ] Muzzle [ ] Eyes [ ] Ears [ ] Neck [ ] Back

[ ] Tail [ ] Rump [ ] Armpits [ ] Front legs [ ] Back legs

[ ] Thighs [ ] Chest [ ] Abdomen [ ] Front Paws [ ] Back Paws

[ ] Groin [ ] Scoots bum

1. Was itching the first symptom that you noticed: [ ] Yes [ ] No
2. What did the problem look like initially:

[ ] Normal skin, just itchy [ ] Pimples [ ] Hair loss

[ ] Rash [ ] Redness

1. Has the problem spread: [ ] Yes [ ] No
2. Have the ears been involved (itchy, infected, waxy): [ ] Yes [ ] No
3. Does your pet experience (check all that apply):

[ ] Cracking Nails [ ] Foot problems [ ] Flaky, dry skin [ ] Hair loss

[ ] Sloughing Nails [ ] Interdigital cysts [ ] Oily, greasy skin [ ] Red skin

[ ] Rash(es) [ ] Head Shaking [ ] Smelly skin [ ] Thick skin

[ ] Red bumps [ ] Ear scratching [ ] Lumps/bumps [ ] Red skin welts

[ ] Pimples [ ] Smelly ears

[ ] Scabs

[ ] ‘Hot Spots’

[ ] Diarrhea [ ] Vomiting [ ] Weight gain [ ] Coughing

[ ] Constipation [ ] Poor appetite [ ] Weight loss [ ] Sneezing

[ ] Gas [ ] Increased appetite [ ] Seizures [ ] Runny eyes

[ ] Increased thirst [ ] Increased Urination [ ] Lameness [ ] Runny nose

[ ] Other:

1. Has your pet received treatment for stomach or intestinal problems/upset:[ ] Yes [ ] No
2. Has your pet ever been diagnosed with any other illnesses:

**Inside Environment**

1. Percent of time spent: Indoors %

Outdoors: %

1. Type of flooring in your house:

Carpets/Rugs: % Any of them wool?[ ] Yes [ ] No

Tile/Wood: %

1. Is the home smoke free: [ ] Yes [ ] No
2. How is the home heated:

[ ] Forced-air [ ] Radiant [ ] Heat Pump

1. When/where are the symptoms at their worst:

[ ] Indoor [ ] Morning

[ ] Outdoor [ ] Night

[ ] No difference [ ] No difference

Describe:

1. Which room does your pet sleep in at night:

[ ] Bedroom [ ] Bathroom [ ] Family Room

[ ] Basement [ ] Laundry Room [ ] Kitchen

[ ] Garage [ ] Other:

1. Where does your pet sleep at night:

[ ] On bed [ ] Tile/wood floor

[ ] Under bed [ ] Carpet

[ ] Beside bed on floor [ ] Pet bed

[ ] Couch/chair [ ] Wool blanket

 [ ] Upholstered

 [ ] Vinyl/leather

1. Which room does your pet spend most of its time in during the day:

[ ] Bedroom [ ] Bathroom [ ] Family Room

[ ] Kitchen [ ] Basement [ ] Garage

[ ] Laundry Room [ ] Outside [ ] Other:

1. Where does your pet spend most of its time during the day:

[ ] On bed [ ] Tile/wood floor

[ ] Under bed [ ] Carpet

[ ] Beside bed on floor [ ] Pet bed

[ ] Couch/chair [ ] Wool blanket

 [ ] Upholstered

 [ ] Vinyl/leather

**Outside Environment**

1. Does your pet spend time around (check all the apply):

[ ] Wooded areas [ ] Dog house [ ] Barns/manure

[ ] Decaying vegetation (mulches, leave, woodpiles, compost)

[ ] Vegetable garden

[ ] Areas of water (ditches, ponds, lakes, ocean, river)

1. What types of trees are in your yard/neighborhood:
2. While in your yard, does your pet spend time on:

[ ] Grass [ ] Deck [ ] Cement/tiles

**Drug History- please check all the apply**

**\*\*Please bring along all medications that you are currently using or have used in the past\*\***

[ ] **Antihistamine (ie. Benadryl)**: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Cortisone (ie. Prednisone, Vanectyl):** When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Cortisone Injections**: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Atopica:** When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Apoquel:** When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Cytopoint Injections:** When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Serum Allergy Injections:** When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Antibiotics:** What kind: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Shampoo:** What kind: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Flea control:** What kind: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Ear meds:** What kind: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Eye meds:** What kind: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

[ ] **Topical meds**: What kind: When:

 Did it help: [ ] Yes [ ] No When was it stopped:

Were there any adverse reactions to any of the above: [ ] Yes [ ] No

If yes, please explain:

**Food History**

1. List PET FOODS from the most current to the oldest:
	1. Brand:

How long was it fed for:

List first 5 ingredients:

Brand:

How long was it fed for:

List first 5 ingredients:

* 1. Brand:

How long was it fed for:

List first 5 ingredients:

* 1. Brand:

How long was it fed for:

List first 5 ingredients:

* 1. Brand:

How long was it fed for:

List first 5 ingredients:

If there are more than 5 diets, please list them on a separate sheet and bring to your appointment

1. List TREATS from most current to oldest (cookies, biscuits, chews, etc.)
	1. Brand:

How often is it given:

List first 5 ingredients:

* 1. Brand:

How often is it given:

List first 5 ingredients:

* 1. Brand:

How often is it given:

List first 5 ingredients:

* 1. Brand:

How often is it given:

List first 5 ingredients:

* 1. Brand:

How often is it given:

List first 5 ingredients:

If there are more than 5 treats, please list them on a separate sheet and bring to your appointment

1. List HUMAN FOOD that is given:
	1. Food: How often is it given:
	2. Food: How often is it given:
	3. Food: How often is it given:
	4. Food: How often is it given:
	5. Food: How often is it given:
	6. Food: How often is it given:
2. When you change diets/treats, do you notice your pet getting better: [ ] Yes [ ] No

Explain:

1. Do you feed any supplements: [ ] Yes [ ] No

Is yes, what:

Please do not hesitate to call us if your have any troubles with this form and we look forward to helping you and your pet at your appointment