OKLAHOMA VETERINARY SPECIALISTS

CLIENT NAME ________________________________ **PET'S NAME** ___________________________________

Chief complaint (s) ____

Age of pet when acquired: ______ Current Age: ______ Approx date problem started: ________________________

Is your pet spayed or neutered? ____ Yes ____ No If no, date of last heat cycle: ______________________________

Is condition: ____ Seasonal ____ Continuous If continuous, was it initially seasonal? ____Yes ____ No

Is there a time when the disease is: ______________ Less severe _____________ Itching is less intense?

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

Are symptoms worse: ____ Indoors ____ Outdoors ____ Night ____ Morning

What was the problem like initially: __Normal skin, just itchy __Hair loss __Rash __Pimples __Redness

Where did problem start?

____Nose ____Neck ____Rump ____Back legs ____Abdomen
____Eyes ____Back ____Front legs ____Back paws ____Groin
____Ears ____Tail ____Front paws ____Chest

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

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

____Nose ____Neck ____Front legs ____Rump
____Eyes ____Chest ____Back legs ____Tail
____Muzzle ____Back ____Back paws
____Ears ____Abdomen ____Front paws
____Armpits ____Groin ____Inner thighs/legs

Comments: ____

Does your pet do/have any of the following?

____Cough ____Vomit ____Runny eyes
____Sneeze ____Diarrhea ____Drink excessively
____Limp ____Urinate excessively ____Get ear infections

If yes, please list frequency and description: ____
____

Do you have other pets? ____Yes ____No List Species: ____

If you have other pets, are they affected? ____Yes ____No Describe: ____________________________________

Do you or anyone in your household have skin problems? ____Yes ____No Describe: _______________________

Do your pet's littermates or parents have skin problems? ____Yes ____No Describe: _______________________

Do you use flea control on your pet? ____Yes ____No Type: ____

Do you use environmental flea control in your home and/or yard? ____Yes ____No Frequency: ______________

Please list medication/injections your pet has been on for the skin condition: ______________________________
____

Other medications your pet is on: ____

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 check the number of bowel movenets your pet has per day: ____1 ____2 ____3 ____4 ____5 ____6

Has your pet received treatment for stomach or intestinal problems? ____Yes ____No

Please check how many times your pet was treated for this condition prior to visiting us: __1 __2 __3 __4 __5

Additional comments: ____