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 movements 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: _____