



Questionnaire for Clients with Dermatologic Patients

Name of pet: _____ Breed: _____

Age: _____ Sex: _____ Male _____ Female

Is your pet: _____ Spayed _____ Neutered _____ Intact _____

Primary concern: _____

Is your pet itchy (including scratching, biting, licking, chewing, rubbing, and head shaking)? _____ Yes _____ No

If yes, on a scale of 0 (not at all) to 10 (very itchy), how itchy is the condition? _____

If yes, where on their body does your pet itch? _____

What percent of time does your pet spend: _____ % Indoors _____ % Outdoors

Does your pet have contact with any other animals? _____

If yes, which and where? _____

Does your pet travel? _____ Yes _____ No If yes, where and when? _____

Do other animals or people in the household have a similar problem? _____

Do you use flea/tick medications for your pet? _____ Yes _____ No

If yes, which product do you use? How frequently? Last application? _____

What does your pet currently eat (including treats)? _____

Have you fed them other foods (including treats)? _____

Where did the skin problem start? _____

_____ Face _____ Paws _____ Back _____ Tail

_____ Ears _____ Legs _____ Stomach Other: _____

What happened when the skin problem first started? _____

____ Itching _____ Redness _____ Discharge _____ Small Bumps _____ Crusting _____ Rash

____ Hair Loss _____ Smell _____ Pimples _____ Large Bumps _____ Dandruff

Other: _____

Age of pet when you first got it: _____ Age when skin problem first started: _____

Does the skin problem happen all year-round? _____ Yes _____ No

Did the problem start off only happening during some parts of the year? _____ Yes _____ No

Are there times of the year when the problem is worse? If so, which? _____

How has the problem changed over time? _____

What treatments has your pet gotten for the skin problem? _____

Have any helped? _____ Yes (if so, please circle the ones that helped) _____ No

Does your pet have any of the following?

____ Vomiting/throwing up _____ Drinking more _____ Sneezing

____ Diarrhea _____ Peeing more _____ Runny eyes

____ Change in eating _____ Coughing Other: _____