



Dermatology History Form

RECHECK Examination

Date: _____

Has your pet improved since the last visit? **YES or NO** _____% improved

What problems are still present _____

If your pet is itching, indicate the **OVERALL** severity of your pet's irritation **AT THIS TIME** (ie over the last 3 days).

(NEVER) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (ALWAYS; ie keeps you up at night)

Where is your pet **ITCHING** (ie scratching, chewing, licking, biting, rubbing) indicate where below (**CHECK** all that apply)

- | | | | |
|--|--------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Nose | <input type="checkbox"/> Neck | <input type="checkbox"/> Tail | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Around eyes | <input type="checkbox"/> Back | <input type="checkbox"/> Front legs | <input type="checkbox"/> Nails |
| <input type="checkbox"/> Around mouth/muzzle | <input type="checkbox"/> Rump | <input type="checkbox"/> Front paws | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Groin | <input type="checkbox"/> Back legs | Comments _____ |
| <input type="checkbox"/> Abdomen/Stomach | <input type="checkbox"/> Sides | <input type="checkbox"/> Back paws | _____ |

Has your pet had an adverse reaction to **ANY** of the medications or treatments prescribed at the last visit? **YES or NO**

Describe _____

Were you able to perform the treatments recommended (ie bathing, giving pills, cleaning the ears, adhering to a Food Trial etc)

Is your pet's appetite normal? **YES or NO** Comments _____ Is your pet's activity level normal? **YES or NO**

Does your pet do any of the following?

- | | | | |
|---------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Vomit | <input type="checkbox"/> Limp | <input type="checkbox"/> Urinate excessively |
| <input type="checkbox"/> Sneeze | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Drink excessively | <input type="checkbox"/> Pant excessively |

Please make a list of any medications and/or prescription foods you will need refills on if they are continued by the dermatologist: