

Dermatology Clinic for Animals

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Patient History Form

Pet's Name _____ Client's Name _____

1. Chief complaint(s) _____

2. Age of pet when you acquired him/her _____ Age now _____

3. Approximate date when problem first started _____

4. Is it seasonal or continuous? _____

5. Was the problem initially seasonal? _____

6. Is there a time when disease is less severe or the itching is less intense? _____

7. What did the problem look like initially? (Please check)

Normal skin, just itchy _____ Hair loss _____ Rash _____ Pimples _____ Redness _____

8. Where did it start? (Please check)

Nose _____ Eyes _____ Ears _____ Neck _____ Back _____ Rump _____ Tail _____ Front paws _____
Back legs _____ Back paws _____ Chest _____ Abdomen _____ Groin _____

9. Has it spread? _____ If so, where? _____

10. Does your pet scratch, rub, chew, lick, or bite the following (Please check)

Nose _____ Muzzle _____ Eyes _____ Ears _____ Neck _____ Back _____ Rump _____ Tail _____
Armpits _____ Front legs _____ Back legs _____ Thighs _____ Back paws _____ Front paws _____
Chest _____ Abdomen _____ Groin _____

11. Was the itching the first thing noticed? _____

12. Do you have other pets? _____

If yes, describe _____

13. Any have skin problems?____
If yes, explain_____

14. Do any people in the household have skin problems?_____

15. Percent of time pet is confined indoors?____ Outdoors?____

16. What is the primary indoor flooring surface? Carpet ____ tile ____ wood ____ other ____
If carpeting, does it contain wool? Yes ____ No ____

17. Are symptoms worse indoors, night, morning?_____

18. If a female, are or were there normal heat cycles?____

19. If a male, does he have normal interest in females?_____

20. Do any relatives of your pet have any skin problems that you are aware of?_____
If yes, explain_____

21. Do you use flea control?____ If yes, circle which ones used: Powder, Dips, Sprays, Collars, Baths, Spot-ons. What brands?_____

22. Do you use insecticides in your home?_____ Frequency_____

23. Please list medications your pet has been on for the problem.
Antihistamines____ Steroid pills____ Steroid shots____ Antibiotics____ Other_____

24. Did any help the problem?____ If yes, which?_____

25. Any other medications, vitamins, food supplements?_____

26. Your pet's regular diet? (brand, ingredients) _____

27. Does your pet have any other health problems? (Please check) Cough____ Sneeze____
Runny eyes____ Vomiting____ Diarrhea____ Tires easily____ Limp____ Drinks excessively____ Urinates excessively____
Back paws____ Chest____ Abdomen____ Groin____

28. How often do you bathe your pet?_____
What shampoo and/or conditioner do you use? _____

29. Is your pet exposed to tobacco smoke? Yes ____ No ____

Comments: _____
