



Dermatology History Form

Dr. Amy Shumaker, DVM, DACVD

Date: _____ Your Name: _____ Patient Name: _____
Name of the Veterinarian/hospital that normally cares for your pet: _____

**Please bring all current/recent medications, shampoos, supplements to your appointment.
Please do not bathe your pet or clean your pet's ears within 48hrs of your appointment.
Please fill out this form as completely as possible:**

Current Issue

1. What is the primary dermatologic problem/reason for your appointment today?

2. How long has the problem been present?

3. Has your pet had a history of skin or ear issues prior to when the current problem started?

4. Is your pet itchy (biting/licking/chewing/scratching/rubbing)? Yes/No

5. If your pet is itchy, please grade the degree of irritation on a scale from 1-10:

(minimal) 1 2 3 4 5 6 7 8 9 10 (severe)

6. Is the skin/ear problem worse or more severe at a certain time of the year, or is it the same throughout the year?

If worse at a certain time of year, what time of year is it worse? _____

Has the pattern changed over time? Yes/No. Become more seasonal? Yes/No. Become more year-round? Yes/No

7. Is the problem worse/better indoors versus outdoors? _____

8. Has your pet traveled outside of the state? Yes/No If yes, when? _____ Where? _____

9. Do you have any other pets? Yes/No. If so, please list species (cat, dog, etc) and number here.

If you have other pets, do any have skin problems? Yes/No. If yes, please describe.

10. Diet Information

What is the Brand name, flavor, type (canned, wet, etc) of food that you feed your pet?

How long have you been feeding this diet? _____

What supplements/vitamins do you give your pet? _____

List any snacks or treats (including human food) that you give your pet.

11. Medication Information

Is your pet currently receiving any medications, supplements, vitamins (oral, topical, injectable)?

Medication name	Dose (mg, ml)	Frequency	Helpful (Yes/No)?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your pet ever had a reaction to any medication? _____

Is your pet on flea control? Yes/No. If yes, what type/frequency? _____

Is your pet on heartworm prevention? Yes/No. If yes, what type? _____

12. How often is your pet bathed/groomed? _____

What shampoo is used? _____

13. Does your pet have any other illnesses or major medical history? If yes, please list here.

14. Does your pet do/have any of the following excessively:

Cough____ Sneeze____ Runny eyes____ Vomit ____ Diarrhea____ Urinate____ Drink Water____

15. Are there any other concerns that we should be aware of with your pet today? _____