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| **Dermatological history - vetderm.ch** |
| Last name and surname pet owner: ………………………………………………………………………………………………………………… Date: Address: …………………………………………………………………………………………………… Phone number: ………………………………………………………………………………………… Email: ………………………………………………………………………………………………………  |
| Name of pet: cat / dog Breed:Date of birth: Sex: |
| Privacy Statement: Hereby, I give my explicit consent to vetderm.ch for the collection, storage, and processing of my pet's data including my contact details for the purpose of maintaining a medical record for medical purposes.  ☐ Yes, I give my consent |
| Referring veterinarian: (please list name and address of your private veterinarian): |
| **General information**Origin of the pet: □ Breeder □ Private □ OtherHow old was your pet when you got it? |
| **Stays abroad**Has your pet ever travelled abroad? □ Yes □ NoIf yes, in which country/countries? |
| **Characteristics of the skin disease**Main reason(s) for consulting a dermatologist: When/at what age did the skin/ear problem occur first?Which body parts were first affected?Which skin lesions did you observe in the beginning?□ Wounds □ pustules □ Hair loss □ red patches □ Wheals/ hives □ Scales □ Crusts □ Other….Did the skin problem change or progress?Has your pet ever had an ear infection? □ No □ Yes When? |
| **Pruritus**Does your pet scratch, bite, rub or lick itself? □ Yes □ No□ Itching occurred prior to skin lesions □ Skin lesions occurred prior to itchingIf yes, where does your pet itch most? □ Head □ Ears □ Arm pits □ Back□ Belly □ Tail □ Paws □ Generalized/ everywhereIf yes, please specify the intensity of itch on a scale of 1 – 10:(1 being no itch, 10 non-intermittent itching) |
| **Seasonality**Is the skin/ear disease seasonal? □ Yes □ No □ Spring □ Summer □ Autumn □ WinterAt which time of day does your pet itch the most? □ Morning □ Midday □ Night □ The whole day |
| **Home environment**Do you have other pets? □ Yes □ NoIf yes, which?□ Cats □ Dogs □ Rodents □ Horses □ Birds □ RuminantsHave you noticed skin/ear problems in other pets or people in the household?If yes, how do they manifest themselves? |
| **Housing** How much time does your pet spend inside (in %)?Where is it the rest of the time?Which kind of floors do you have at home?Do you know about skin/ear problems in other animals of the litter/ family? |
| **For cats**Does your cat live □ strictly indoors □ also go outside?Was your cat ever tested for the following viral diseases? □ FeLV □ FIV □ FIPPlease note here if one of these tests has been positive ………………. |
| **Nutrition**Which type of food do you feed?□ Dry food …………………………………………………………….………………□ Wet/canned food …………………………………………………………………□ Fresh meat …………………………………………………………………………… □ left-overs …………………………………………………………………………….. □ Food additives ………………………………………………………….…………..□ Others ………………………………………………………………………………….**Special diet**Has your pet ever been fed an elimination diet? □ Yes □ NoName of the diet food:……………………………………………………………….Duration of the dietary trial:…………………………………………………………………………Has the dietary trial helped to improve the symptoms? □ Yes □ No |
| **Prophylaxis**When did you deworm your animal the last time?When was the last vaccination?When was the last time that you noticed fleas?Which type of flea or tick preventative do you use?Product(s): How often? When was the last time? |
| **Treatments (Shampoos, lotions, tablets, creams, sprays, ear drops...)**Shampoo: Name ……………………….. □ Yes □ No Success?Antibiotics: Name ……………………….. □ Yes □ No Success? Steroids/cortisone: Name ……………………….. □ Yes □ No Success? Creams: Name ……………………….. □ Yes □ No Success?Antifungals: Name ……………………….. □ Yes □ No Success?Ear drops Name ……………………….. □ Yes □ No Success?Other: Name ……………………….. Success?Which of the mentioned medications has helped best in your eyes?Which medications do you apply/administer at the moment? |
| **General state of health**General condition □ Normal □ ReducedEndurance □ Normal □ Reduced Appetite □ Normal □ Reduced □ IncreasedWeight loss □ Yes □ noWeight gain □ Yes □ noAmount of water intake □ Normal □ Increased Urination □ Normal □ IncreasedFrequency of stools □ Normal □ Reduced □ IncreasedQuality of stools □ Normal □ Abnormal ………………………………………….Eye discharge □ Yes □ NoHeat □ Normal □ Abnormal Date of the last heat?.................................Other diseases/problems:  |
| Is there any further information that could be relevant for the skin/ear disease? |