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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 □ Other  How old was your pet when you got it? |
| **Stays abroad**  Has your pet ever travelled abroad? □ Yes □ No  If 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 itching  If yes, where does your pet itch most?  □ Head □ Ears □ Arm pits □ Back □ Belly □ Tail □ Paws □ Generalized/ everywhere  If 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 □ Winter  At which time of day does your pet itch the most?  □ Morning □ Midday □ Night □ The whole day |
| **Home environment** Do you have other pets? □ Yes □ No  If yes, which?  □ Cats □ Dogs □ Rodents □ Horses □ Birds □ Ruminants  Have 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 □ FIP Please 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 □ No  Name 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 □ Reduced Endurance □ Normal □ Reduced  Appetite □ Normal □ Reduced □ Increased  Weight loss □ Yes □ no Weight gain □ Yes □ no Amount of water intake □ Normal □ Increased  Urination □ Normal □ Increased Frequency of stools □ Normal □ Reduced □ Increased Quality of stools □ Normal □ Abnormal …………………………………………. Eye discharge □ Yes □ No Heat □ Normal □ Abnormal  Date of the last heat?.................................  Other diseases/problems: |
| Is there any further information that could be relevant for the skin/ear disease? |