Surgery:
Jude T. Bordelon DVM, DACVS-SA
Neurology:
Boogie Yates DVM
Dermatology:
Michelle Woodward DVM, MS,DACVD
Integrative Medicine:
Erica L. Fontenot DVM, CVA

BATON ROUGE
VETERINARY SPECIALISTS

3803 S. Sherwood Forest Blvd.
Baton Rouge, L.A. 70816
Phone: 225-227-2967
Fax: 225-636-5768
www.brvetspecialists.com

History Form

Date: _____
Client Name: _____
Pet's Name: _____
Primary Veterinarian: _____

Chief complaint(s):
_____
_____
_____

Age of pet when acquired: _____ Current age: _____ Approx date problem started: _____

Is this the FIRST skin/ear issue? ☐ Yes ☐ No If NO, please briefly explain:
_____
_____

Is your pet: Intact Neutered? If neutered, at what age? _____

Is the condition: Seasonal Continuous Not applicable (this is the first occurrence)

If the problem is now continuous, was it initially seasonal/intermittent? Yes No

Is there a time when the disease is more severe? ☐ Yes ☐ No
If yes, when? _____

Percent of time pet is kept: Indoors _____ % Outdoors _____ %

Are symptoms worse: Indoors Outdoors Night Morning

How itchy is your pet on a scale of 1 to 10 (with 10 being extremely itchy)? _____

What was the problem like initially? Normal skin but itchy Hair loss Rash/Pimples Redness

Where did the problem START? Nose Eyes Ears Neck Back Rump Tail Front legs Front paws Back legs Back paws Chest Abdomen Groin

Does your pet scratch, rub, chew, lick, or bite any of the following areas? Nose Muzzle Eyes Ears Neck Chest Back Rump Tail Armpits Front legs Front paws Back paws Back legs Abdomen Groin Inner thighs and leg

What are the TOP 3 locations your pet scratches, rubs, licks, or bites?
_____

Does your pet do any of the following? If YES, list frequency and description.

Cough Yes No
_____

Runny eyes Yes No
_____

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Diarrhea Yes No

Loss of appetite Yes No

Urinate excessively Yes No

Sneeze Yes No

Get ear infections Yes No

Vomit Yes No

Drink excessively Yes No

Limp Yes No

Do you have other pets? Yes No List species:

If you have other pets, do they have skin issues? Yes No Describe:

Do you or anyone in your household have skin issues? Yes No Describe:

Do your pet's littermates or parents have skin issues? Yes No Unknown Describe:

Do you use flea control on your pet? Yes No
Type:_____
Frequency: _____
When was the last application?_____
Do you use environmental flea control in your home and/or yard? Yes No
Frequency: _____
Please list all medications/injections your pet has received for the dermatologic condition.

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Did any of the above medications help the problem? Yes No
Which one(s)?

_____

Please list all medications/supplements/vitamins your pet is CURRENTLY taking (name/dosage/frequency).

_____
_____
_____
_____

How often do you bathe your pet and what shampoos are used?

_____
_____

What is your pet's current diet, including treats/table scraps?

_____
_____

How long has your pet been on this diet?

_____

Please check the number of bowel movements your pet has per day: 1 2 3 4 5+
Has your pet received treatment for stomach or intestinal problems? Yes No
If yes, describe:

_____

Please check the number of times your pet was treated for this condition prior to visiting our clinic:
1 2 3 4 5 6+
Additional comments:

_____
_____
_____