



NEW PATIENT OWNER QUESTIONNAIRE

DATE OF APPOINTMENT (if known)
(Month/Day/Year)

OWNER AND PET INFORMATION

Your first and last name(s)

Your pet's name

SECTION 1. IS ITCHING THE REASON FOR THE CONSULTATION WITH THE DERMATOLOGIST?

1.1. Is any of the following the primary reason for today's visit? Itching, scratching, chewing, biting, nibbling, licking, rubbing of any part of the body.

No. Skip to page 3. Yes. Proceed to next question.

1.2. Please check all parts of the body that apply.

Feet, paws Ears Face Armpits

Back Belly, stomach Chest Chin

Eyes Groin Legs Neck

Nose Rump Sides/flanks Tail

Somewhere else:

1.3. Which of the following statements best describes the seasonality of itching or ear problems in your pet over the last 12 months? One response only.

I cannot answer this question because the problems have been going on for less than a year. Skip to next question.

The pet itches the same all year round (absolutely no increase in itch in winter compared with warm weather months). This was true from the onset.

The pet used to have a warm weather seasonal itch that has evolved into a year-round itch gradually over time.

The pet itches all year round but itching increases noticeably in the winter (especially when the forced-air heating is turned on).

The pet itches all year round but itching increases noticeably in the warm weather months when the pollens are out.

The pet does not itch at all in the winter but itching occurs in the warm weather months when the pollens are out.

1.4. If you pet's itching seems to get worse sometimes, please check all that apply.

Mainly in the spring Mainly in the summer Mainly in the fall

At night In the morning After eating

In the house Outside, in contact with vegetation (mowed grass, trees, weeds, plants)

After this medication:

After this situation or event:

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

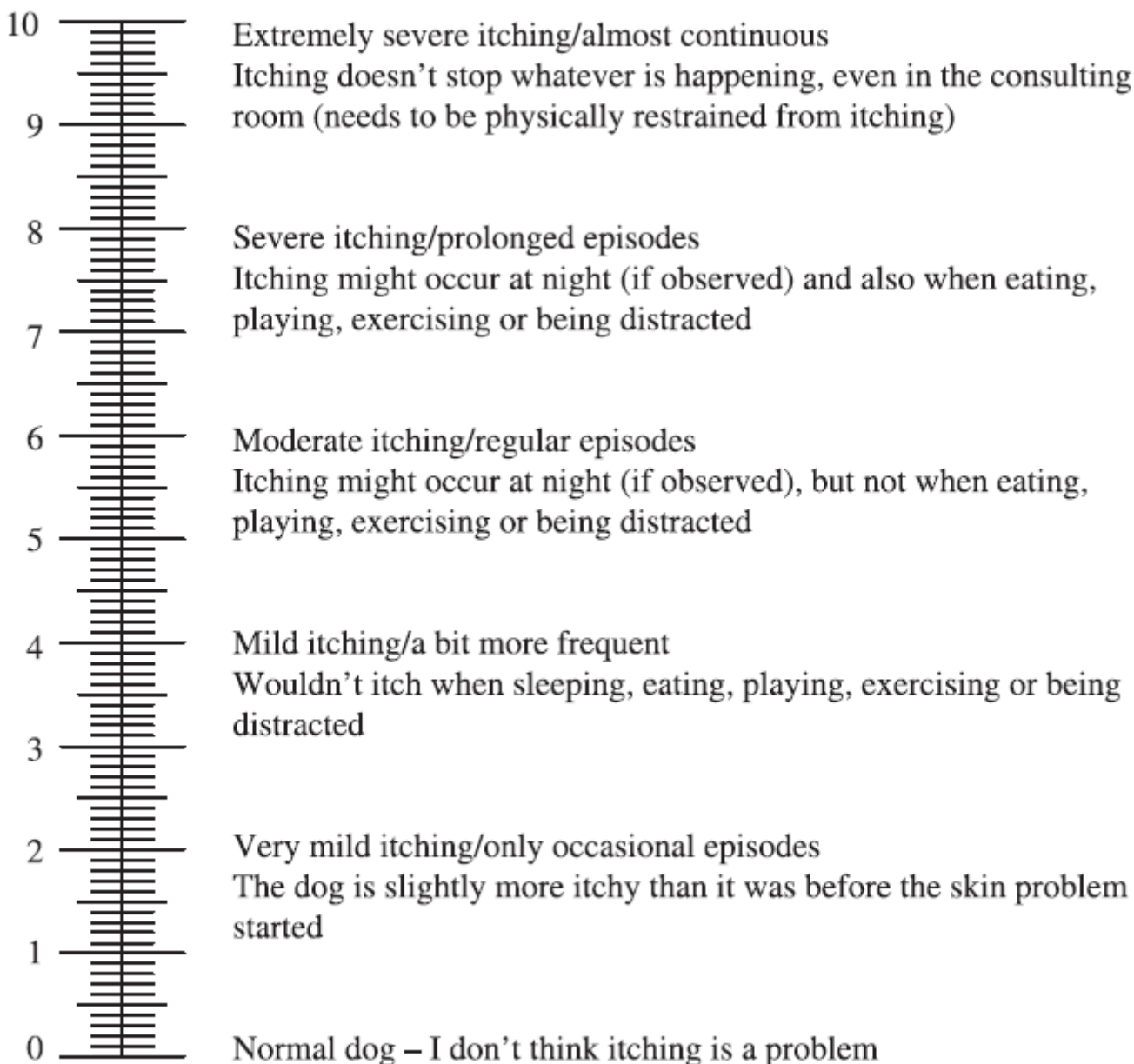
Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

SECTION 2. HOW SEVERE IS YOUR PET'S ITCHING?

The behavioral scale below is designed to measure the severity of itching. Read all the descriptions below starting at the bottom. Then place a mark anywhere on the vertical line to indicate the point at which you think your pet's level of itchiness currently lies.



We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

NEW PATIENT OWNER QUESTIONNAIRE

Page 3

SECTION 3. ARE THERE ANY PROBLEMS OTHER THAN ITCHING?

3.1. Please check any of the following problems that pertain to your pet.

<input type="checkbox"/> Curving nails <input type="checkbox"/> Cracking nails <input type="checkbox"/> Breaking nails <input type="checkbox"/> Sloughing nails	<input type="checkbox"/> Foot problems (pododermatitis) <input type="checkbox"/> Interdigital cysts	<input type="checkbox"/> Flaky, dry skin (dandruff) <input type="checkbox"/> Oily, greasy skin <input type="checkbox"/> Smelly skin	<input type="checkbox"/> Hair Loss (alopecia) <input type="checkbox"/> Red skin (erythema) <input type="checkbox"/> Thick skin (Elephant skin)
<input type="checkbox"/> Rash(es) <input type="checkbox"/> Red bumps (papules) <input type="checkbox"/> Pimples (pustules) <input type="checkbox"/> Scabs (crusts) <input type="checkbox"/> "Hot spots"	<input type="checkbox"/> Head shaking <input type="checkbox"/> Ear scratching <input type="checkbox"/> Smelly ears (otitis)	<input type="checkbox"/> Lumps, bumps (nodules, masses)	<input type="checkbox"/> Red skin welts (urticaria/wheals)
<input type="checkbox"/> Change in stool consistency	<input type="checkbox"/> Gas, flatulence	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Scooting (rubbing bum on floor)		<input type="checkbox"/> Weight loss
<input type="checkbox"/> Coughing	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Runny eyes	<input type="checkbox"/> Runny nose
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Increased urination
<input type="checkbox"/> Lameness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tiredness / lethargic behavior	

Other:

3.2. How many bowel movements does your pet have per day?

I'm not sure. Skip to next section.
 Number: _____ / day

SECTION 4. HOW LONG HAVE THE PROBLEMS BEEN PRESENT?

I'm not sure. Skip to page 4.
 Duration (in years or months or weeks): _____

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

NEW PATIENT OWNER QUESTIONNAIRE

Page 4

SECTION 5. ORIGIN, TRAVEL HISTORY, ENVIRONMENT, OTHER ANIMALS, PEOPLE IN YOUR HOUSEHOLD, GROOMING			
5.1. How old was the pet when adopted?			
<input type="checkbox"/> I'm not sure. Skip to next question.		<input type="checkbox"/> Age (in years or months or weeks): _____	
5.2. Where was the pet adopted (ie. pet store, breeder, SPCA etc.)?			
5.3. Has the pet traveled outside of the province of British Columbia?			
<input type="checkbox"/> No. Skip to next question.		<input type="checkbox"/> Yes. Where, when:	
5.4. Has your pet been out of his or her usual environment recently (ie. vacation, play date, day-care, visit to family or friends, kennel, pet-sitter, etc.)?			
<input type="checkbox"/> No. Skip to next question.		<input type="checkbox"/> Yes. Details:	
5.5. Please check any of the following that are present in your pet's environment.			
<input type="checkbox"/> Carpet(s) <input type="checkbox"/> Rug(s) <input type="checkbox"/> Wool blanket(s) <input type="checkbox"/> Feather blanket(s), duvet(s)		<input type="checkbox"/> Forced-air heating <input type="checkbox"/> Radiant heating <input type="checkbox"/> Tobacco smoke	
<input type="checkbox"/> Swimming in ocean <input type="checkbox"/> Swimming in lake <input type="checkbox"/> Swimming in river			
5.6. Do you have any other indoor animals?			
<input type="checkbox"/> No. Skip to next question.		<input type="checkbox"/> Yes. Details:	
5.7. Do you have any other outdoor animals?			
<input type="checkbox"/> No. Skip to next question.		<input type="checkbox"/> Yes. Details:	
5.8. Do any of your other animals have skin problems?			
<input type="checkbox"/> No. Skip to next question.		<input type="checkbox"/> Yes. Details:	
5.9. Do any people in your house have skin problems?			
<input type="checkbox"/> No. Skip to next page 5.		<input type="checkbox"/> Yes. Details:	

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

NEW PATIENT OWNER QUESTIONNAIRE

Page 5

5.10. How much time does your pet spend in the house?

Stays in the house all the time Never comes in the house

If goes outside, percentage of time spent outdoors: _____ %

5.11. Do you (or someone else) bathe/groom your pet at home?

No. Skip to next question Yes. Frequency and products:

5.12. Do you (or someone else) bathe/groom your pet somewhere else?

No. Skip to next section Yes. Frequency and products:

SECTION 6. DIET HISTORY

6.1. What does your pet eat?

Please tell us brands and check the labels for main ingredients (ie. chicken, beef, lamb, rice, corn, wheat etc.)

Canned food

Dry food

Raw food

Treats

Human food

Other

6.2. When did you start feeding the current diet?

I'm not sure. Skip to page 6. Duration (in years or months or weeks): _____

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

NEW PATIENT OWNER QUESTIONNAIRE

Page 6

6.3. Have hypoallergenic diets been tried?			
<input type="checkbox"/> No. Skip to next section.		<input type="checkbox"/> Yes but it did not help the skin problems.	
<input type="checkbox"/> Yes and it helped with the skin problems.		<input type="checkbox"/> Yes and it helped with the gastrointestinal problems.	
6.4. Please check any of the following statements that pertain to the previous use of hypoallergenic diets.			
<input type="checkbox"/> There were so many that I can't remember			
<input type="checkbox"/> I tried the following diet(s) prescribed by my veterinarian(s). Please check all that apply.			
<input type="checkbox"/> Hills z/d Low Allergen	<input type="checkbox"/> Hills z/d Ultra Allergen Free	<input type="checkbox"/> Medical Hypoallergenic	<input type="checkbox"/> Medical Gastro
<input type="checkbox"/> Hills d/d duck/green pea	<input type="checkbox"/> Hills d/d duck/potato	<input type="checkbox"/> Hills d/d salmon/potato	<input type="checkbox"/> Hills d/d venison/green pea
<input type="checkbox"/> Eukanuba Iams fish/potato	<input type="checkbox"/> Eukanuba Iams kangaroo/oat	<input type="checkbox"/> Purina DRM	<input type="checkbox"/> Royal Canin Skin Support
<input type="checkbox"/> Medical Vegetarian		<input type="checkbox"/> Purina HA	<input type="checkbox"/> Royal Canin HP 19 or 23
<input type="checkbox"/> Royal Canin Sensitivity catfish/rice		<input type="checkbox"/> Royal Canin Sensitivity venison/rice	<input type="checkbox"/> Royal Canin Sensitivity duck/rice
<input type="checkbox"/> I tried the following over-the-counter diets; raw or home-cooked ingredients. Add an extra page if needed. Please try to remember the brands and main ingredients (ie. duck, venison, rabbit, brushtail, kangaroo, fish, salmon, green pea, sweet potato, potato etc.)			
SECTION 7. OTHER ILLNESSES, CURRENT AND PREVIOUS TREATMENTS			
7.1. Does your pet have any other illnesses?			
<input type="checkbox"/> No. Skip to page 7.		<input type="checkbox"/> I'm not sure.	
<input type="checkbox"/> Yes, now. Details:		<input type="checkbox"/> Yes, in the past. Details:	

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

NEW PATIENT OWNER QUESTIONNAIRE

Page 7

7.2. Does your pet have any known adverse/allergic reactions to medications (ie. antibiotics, anesthesia, sedation, vaccinations, shampoos, ear cleaners, ear drops etc.)?

No. Skip to next question.

Yes. Details:

7.3. List any medications (oral, shampoo, ear drops, thyroid and heart medications etc.) your pet is currently taking. Include all treatments that are over-the-counter. Add an extra page if needed.

-
-
-
-
-
-
-
-
-
-
-

7.4. Please check any of the following statements that pertain to the use of medications for skin.

There were so many that I can't remember. Skip to page 8.

My veterinarian(s) can give you the information about prescription medications.

The itch goes away completely as long as my pet gets steroids (ie. Vanectyl-P, prednisone, prednisolone).

The itch is partially controlled as long as my pet gets antihistamines (ie. Benadryl, Reactine).

The rashes go away completely with antibiotics but keep coming back.

I tried cyclosporine (Atopica).

I tried allergy shots.

I have tried everything and nothing works.

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!

SECTION 8. FLEA EXPOSURE AND FLEA CONTROL			
8.1. Does your pet have fleas?			
<input type="checkbox"/> No. Skip to next question.		<input type="checkbox"/> I'm not sure.	
<input type="checkbox"/> Yes, now. Details:		<input type="checkbox"/> Yes, in the past. Details:	
8.2. Do you use flea control products on your pet?			
<input type="checkbox"/> No. Skip to next section.			
<input type="checkbox"/> I use(d) the following products(s) prescribed by my veterinarian(s). Please check all that apply.			
<input type="checkbox"/> Advantage	<input type="checkbox"/> Advantage Multi	<input type="checkbox"/> Capstar	<input type="checkbox"/> Comfortis
<input type="checkbox"/> Interceptor	<input type="checkbox"/> K9 Advantix	<input type="checkbox"/> Program	<input type="checkbox"/> Revolution
<input type="checkbox"/> Sentinel	<input type="checkbox"/> Other(s):		
8.3. How do you use the flea control products?			
<input type="checkbox"/> Year-round	<input type="checkbox"/> Warm weather months only	<input type="checkbox"/> On this pet only	<input type="checkbox"/> On all pets in the household
SECTION 9. ADDITIONAL HISTORY			
Please provide below any other information that you feel may be helpful (ie. pet's temperament, special requests/concerns, your expectations as the pet's owner etc.). Add an extra page if needed.			

We are looking forward to seeing you and your pet. In order to help us understand your pet's problems, please complete all sections of this questionnaire. Your answers will help us give your pet the best care possible. If you are unsure of how to respond to a question, please ask during the office visit.

Remember to bring the completed form with you to the appointment.

If you are unable to keep this appointment, please call (250) 590-8445 at least 48 hours in advance to cancel.

Thank you very much!