



PET EMERGENCY TREATMENT SERVICES INC.
KEVIN SHANLEY, DVM, DACVD
NEW PATIENT HISTORY

Appointment Date:

Owner's Name:

Owner's Address:

Owner's Telephone Number:

Pet's Name

Referring Veterinarian:

1. HOW OLD WAS YOUR PET WHEN YOU OBTAINED HIM/HER?
2. HOW OLD WAS YOUR PET WHEN THE SKIN/EAR PROBLEMS BEGAN?
3. WHAT IS YOUR PET'S MAIN PROBLEM?
4. RATE THE ITCH LEVEL ON A SCALES OF 1-10:
5. WHAT ARE THE AFFECTED AREAS?
6. WHERE ON YOUR PET'S BODY DID THE PROBLEM FIRST BEGIN?
7. IS THE SKIN/EAR PROBLEM SEASONAL OR YEAR ROUND?
8. IF SEASONAL, IN WHICH SEASONAL DOES THE PROBLEM OCCUR?
9. IF YEAR ROUND, DOES THE PROBLEM GET WORSE DURING ANY PARTICULAR SEASON?
10. DID THE ITCHING BEGIN BEFORE OTHER SIGNS?
11. DO YOU HAVE ANY OTHER PETS?
12. DO ANY OTHER PETS HAVE SKIN/EAR PROBLEMS OR ITCHING?
13. DO ANY RELATIVES OF YOUR PETS HAVE SKIN/EAR PROBLEMS?
14. DO ANY PEOPLE IN THE HOUSEHOLD HAVE SKIN PROBLEMS?

15. HAS YOUR PET EVER BEEN OUT OF THE AREA?

16. WHAT IS YOUR PET'S CURRENT DIET?

16A. HAS YOUR PET EVER BEEN ON A PRESCRIPTION DIET TO RULE OUT FOOD ALLERGIES?
IF SO, WHICH ONE?

16B. LIST ANY OTHER FOODS, TREATS, ETC THAT YOUR PET RECEIVES ROUTINELY:

17. WHAT PERCENTAGE OF TIME DOES YOUR PET SPEND INDOORS/OUTDOORS?

17A. WHAT IS THE PRIMARY INDOOR FLOORING SURFACE?

17B. IF CARPETING, DOES IT CONTAIN WOOL?

17C. DOES ANYONE IN THE HOUSEHOLD SMOKE?

18. DOES YOUR PET HAVE ANY OTHER SIGNS OF ILLNESS?

19. WHAT IS YOUR PET'S FLEA CONTROL?

19A. HOW OFTEN IS IT APPLIED?

20. LIST THE MEDICATIONS (INCLUDING TOPICALS AND SHAMPOOS) YOUR PET HAS
RECEIVED FOR THEIR SKIN/EAR CONDITION:

21. WHAT MEDICATION(S) IS YOUR PET CURRENTLY RECEIVING?

ADDITIONAL HISTORY: