Veterinary Dermatology of Richmond

Exam Form

Client Name: ____________ Date: ____________

Patient Name: ____________

	Where:	**How Often:**	**First Noticed:**
Scratching			
Licking/Chewing			
Hair Loss			
Body Odor			
Lesions			
	Occurring/Changes:	**How Often:**	**First Noticed:**
Head shaking			
Scooting			
Gas/flatulence			
Vomiting			
Diarrhea			
Change in appetite			
Change in water intake			
Urination change			
Energy level			

Itch Level Scale 0 (none) to 10 being the worst (can not walk across the room without stopping to itch)

Current itch level: ____________ **Previous itch level :** ____________

Owner's perception of progress:

Concerns:

Name of medication	MG	Amount given/AM PM	How much left?	Do you need more/ how much?

Cytopoint: ______ Did it help? ______ How quickly? ______ Repeat? ______

	How often:	Last:	Refills:
Ear meds at home:			
Ear cleaner:			
Shampoo:			
Heartworm prevention:			
Flea/tick prevention:			
Allergy serum: INJ / SL			
Any problems BEFORE or AFTER allergy serum?			

Does bathing help/how long? ______

Brand/Dry	Brand/Canned	Treats	Table Food	Pills	Forbidden Food
					Any problems?

When did your pet last eat/drink? ______