



ALLERGY HISTORY QUESTIONNAIRE

Owner's Name _____ Date _____

Pet's Name _____ Breed _____ Age _____ Sex _____

Primary Complaint _____

If itching (scratching, chewing, licking, rubbing, biting), which areas are affected?

Face (), Feet (), Armpits (), Rear (), Generalized ()

Respiratory (wheezing, sneezing, coughing)? _____

Date or age symptoms were first noted. _____

Are symptoms worse in Spring (), Summer (), Fall (), Winter (), Year-round ()

Are symptoms getting worse? _____ What aggravates symptoms? _____

What helps symptoms? _____

Do any of the following occur? Sores (), Scabs (), Scaling (), Hair loss (), Odor (),

Redness (), Watery eyes (), Ear problems (), Sweating (), Vomiting (),

Drinks excessive water (), Ravenous appetite (), Diarrhea (), Weight gain / loss ()

When did you last see a flea on your pet? _____

What do you normally feed your pet (type & brand) _____

Is your pet allergic to any food? If yes, specify. _____

Allergic to any drug or medication? _____

Do you have other pets? Cats (), Dogs (), Birds (), Other ()

If yes, do they have any skin problems (specify) _____

Do you know of any relatives of this pet that have skin problems? _____

Does any human member of the household have skin problems? _____

Where does this pet sleep? _____ Other illnesses & dates _____

Does bathing help or aggravate? _____

Previous medications: Shampoos _____, Dips _____, Sprays _____, Powders _____, Ointments _____, Tablets or capsules _____

Last dose given _____ Response _____

Injection _____ Date _____ Response _____

Previous veterinarian (s) _____

Previous diagnosis _____

What do you think is the cause of this problem _____