

# DERMATOLOGY ADMISSION FORM

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**Long Island  
Veterinary Specialists**

*Where You Take Your Pet First Makes All The Difference*

## CLIENT INFORMATION

Client's Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

## PATIENT INFORMATION

Pet's Name \_\_\_\_\_

Canine

Feline

Breed \_\_\_\_\_

Male Neutered

Female Spayed

Age \_\_\_\_\_ Color \_\_\_\_\_ Weight \_\_\_\_\_

Male Intact

Female Intact

1. Describe the skin problem you are bringing your pet in for:

\_\_\_\_\_  
\_\_\_\_\_

2. How old was your pet when the skin problem first started? \_\_\_\_\_

3. Did the problem start suddenly or gradually over time? \_\_\_\_\_

4. Is the problem (check one):  All year round  Intermittent

5. Is the problem worse during certain times of the year?  Yes  No

If yes, when (check all that apply)?  Spring  Summer  Fall  Winter

6. Has your pet ever had an ear infection?  Yes  No

If yes, when (check all that apply)?  Spring  Summer  Fall  Winter

7. Is your pet itchy (this includes any licking, chewing, rubbing, biting, or scratching)?  Yes  No



8. Rate your pet's level of itch on a scale of 0 (no itch) to 10 (your pet's most severe itch).

Write a number 1 to 10 here \_\_\_\_\_

9. List the locations on your pet's body where they are itchy

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10. What did you notice first (check one)?  Skin lesions  Itch  Both

11. List ALL medications your pet is CURRENTLY taking (including any topicals, supplements, or medications for other conditions not related to the skin). Indicate the response to these treatments if known.

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12. List PREVIOUS medications used to treat your pet's skin/ears (including any topicals or supplements). Indicate the response to these treatments if known.

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13. Is your pet primarily (check one):  Indoor  Outdoor  Both

14. What flea/tick prevention are you using (list type)? \_\_\_\_\_

Given (check one):  Year round  Seasonally

15. What heartworm prevention are you using (list type)? \_\_\_\_\_

Given (check one):  Year round  Seasonally

16. What other pets are in the household? \_\_\_\_\_

Are the other pets primarily (check one):  Indoor  Outdoor  Both

Are the other pets in the household receiving flea/tick prevention?  Yes  No

List type: \_\_\_\_\_



17. Does your pet have contact with any animals outside of your home (list location and types of animals) (ex. dog daycare, boarding, etc.)?

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18. Do any other pets or people in the household have skin problems?  Yes  No

19. What do you feed your pet (include treats, chews, table food, etc.)?

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20. Does your pet have a sensitive stomach associated with feeding different types of food (ex. vomiting, diarrhea, etc.)?  Yes  No

21. Have different diets been tried as treatment (list brand name & duration given)?  Yes  No

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22. Does your pet have any travel history (list location)?  Yes  No

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23. List any other diagnosed medical illnesses:

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