

# WHAT IS MAKING MY DOG SO ITCHY?

## Evaluation Form

A thorough history can help us find the source of your dog's itching more quickly.

Please answer the following questions to help guide the diagnostic process.

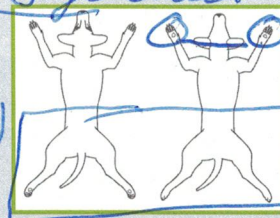
Date \_\_\_\_\_ Pet owner name \_\_\_\_\_

Name of dog \_\_\_\_\_ Age \_\_\_\_\_ Breed \_\_\_\_\_ Weight \_\_\_\_\_

## PHYSICAL EVALUATION

Please check any that describe your dog and circle problem areas on the drawing.

- Hair loss
- Foul odor
- Inflammation or redness
- Itching/Scratching
- Otitis (ear infections)
- Licking/Chewing
- Skin lesions (sores)
- Changes in skin (reddish brown stains, discolorations and/or areas that are thick and leathery)
- Other \_\_\_\_\_



**CIRCLE PROBLEM AREAS**  
(Itching, hair loss, lesions, etc.)

- Has your dog ever had ear problems?  Yes  No
- Does your dog have any chronic gastrointestinal signs like diarrhea or vomiting?  Yes  No

## SEVERITY EVALUATION

On a scale of 0 to 10 rank the severity of your dog's symptoms.

### SEVERITY OF CONDITION OVERALL

0 1 2 3 4 5 6 7 8 9 10  
No symptoms Severe

### SEVERITY OF SKIN LESIONS

0 1 2 3 4 5 6 7 8 9 10  
No lesions Severe

### SEVERITY OF SCRATCHING/LICKING/CHEWING

0 1 2 3 4 5 6 7 8 9 10  
No signs Severe

*Food Allergy*  
*Secondary Infection Present*  
*Yeast, Scabies, Insect*

## ONSET AND SEASONALITY EVALUATION

- Is this the first time your dog has experienced these symptoms?  Yes  No
  - If no, at what age did the symptoms first occur?  <1 yr  1-3 yrs  4-7 yrs  7+ yrs
  - If no, has it occurred around the same time of year each time?  Yes  No
  - If no, approximate time of year symptoms occur. \_\_\_\_\_
- How long have the current symptoms been going on? \_\_\_\_\_
- Did the itch start gradually and over time become worse?  Yes  No
- Did the itch come on suddenly without warning?  Yes  No
- Was there a "rash" first or itching first? Or simultaneous?  Rash first  Itch first  Simultaneous

*Insect Food* *Atopy*

*Endocrine* *Allergy*

## PARASITE CONTROL

- Is your dog on a flea/heartworm preventative?  Yes  No
  - If yes, what product(s)? \_\_\_\_\_
- What months do you administer the preventative? \_\_\_\_\_
- When was the last time you administered the parasite control? \_\_\_\_\_