Main Problem: ___

Questions/Concerns: __

Duration: ___

Frequency: ___

Progression: ___

If itching- scratching on a scale of 1-10: ___

If itching- 3 areas scratching the most: ___

Itching is worse during the:___

Eating: ___

Drinking: ___

Urination: ___

Defecation: ___

Activity Level: ___

Diet brand: ___

Are you aware if your diet is grain-free? ___

How much does patient get fed and how often: ___

Heartworm prevention: ___ When was last dose given? ___

Flea/Tick Prevention: ___ When was last dose given? ___

Medications/Supplements: ___

Indoor/Outdoor: ___