Pet Allergy Laboratory, Inc. - Pet History Form

Date: __________ Clinic: _______________________ Veterinarian: _______________________

Animal's Name: _________________________ Owner's Name:___________________________

Animal's Age:_____ Breed: _______________ ☐ Male ☐ Neutered ▪ ▪ ▪ ☐ Female ☐ Spayed

Check all symptoms that apply to your pet:

☐ Scratching ☐ Hair Loss ☐ Pimples ☐ Dry Skin ☐ Coughing
☐ Red Skin ☐ Hives ☐ Odor ☐ Oily Skin ☐ Sneezing
☐ Ear Problems ☐ Runny Nose ☐ Vomiting ☐ Diarrhea ☐ Other _________
☐ Darkened/Thickened Skin

Check all areas where your pet has skin problems:

☐ Tail ☐ Back ☐ Chest ☐ Abdomen ☐ Groin
☐ Rump ☐ Legs ☐ Paws ☐ Face ☐ Ears
☐ Eyes ☐ Neck ☐ Other ____

At what age did the first symptoms appear? _______
How long have symptoms been occurring? ________ Has the problem spread? ☐ Yes ☐ No

When are the symptoms worse:

☐ Winter ☐ Spring ☐ Summer ☐ Fall ☐ Not Seasonal

Check all that apply to your pet's environment:

☐ Lives Outdoors ☐ Rural Home ☐ Travels Often ☐ New Residence
☐ Lives Indoors ☐ City Home ☐ Boarded Often ☐ New Furnishings

Do the symptoms show any correlation with the above environmental factors: ☐ Yes ☐ No
If Yes, please explain: ____

What variety of foods does your pet eat? (Please check all that apply)

☐ Dry/Kibble ____________________________ ☐ Canned ___________________________________
☐ Table Scraps ____

Has your pet been on a food elimination trial? ☐ Yes ☐ No If yes, did it help? ☐ Yes ☐ No
Is your pet on a food elimination trial/diet now? ☐ Yes ☐ No
If yes, what foods are in the diet? ____

Does your pet have any other conditions or illnesses? ___________________________________

To be completed by Veterinarian

Which other diagnostic tools have been used on this patient and what was the result?

☐ Thyroid Check _______________________ ☐ Food Trial ______________________________
☐ Scrapings ____________________________ ☐ Biopsy _________________________________

Which treatments have been used on this patient and what, if any, was the response?

☐ Steriods ______________________________ ☐ Antihistamines ___________________________
☐ Antibiotics ____________________________ ☐ Shampoos/Topicals ________________________
☐ Mange Treatment _______________________ ☐ Immune Stimulants _______________________
☐ Holistic Treatments _____________________ ☐ Desensitization __________________________

Is the patient currently on Allergy Injections? ☐ Yes ☐ No
Has this patient been previously allergy tested? ☐ Yes ☐ No If yes, where? __________
Describe the patient's symptoms:____
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