



ANIMAL ALLERGY & EAR CLINIC of Oregon LLC

4100 SW 109th Avenue
Beaverton, OR 97005
503-574-4150 (Fax) 503-644-6679

Amy Randall, DVM, MS, Diplomate ACVD

Date ____/____/____

Current Concern: _____

Client Information

First Name	Spouse/Partner	Last Name
Address		
City	State	Zip
Primary Contact Phone	Work Phone	Cell/Pager
E-mail Address:		
Occupation / Work Place	Occupation / Work Place <Spouse>	

Patient Information

Pet's Name _____ (Please Circle One)
Canine Feline Other

Breed _____ Color _____ DOB _____

Male _____ Female _____ Spayed/Neutered _____ or Intact _____ Weight _____ lbs.

Any known allergic or drug reactions? _____

Primary Veterinarian

Dr. _____
First Name Last Name Hospital/Clinic

Address _____

City _____ State _____ Zip _____

Office Phone # _____ Fax # _____ Pharmacy's Phone # _____

Would you like information from AAEC shared with your Primary Vet? YES NO
(Please Circle One)

*Please Note: Any unpaid balance may accrue at an interest rate of 1.00% per month.
 Clients may be charged a fee for cancelling their appointment without at least 24 hrs notice.
 I have read and acknowledge these terms and conditions.*

Signature



Client Interview and Questionnaire

- 1 At what age did your pet's skin problem start? _____
- 2 What brand of dry food do you feed routinely? _____ Can Food? _____
- 3 Please circle main protein source <flavor> of pet's diet: *Beef* *Lamb* *Chicken* *Other*
- 4 Do you feed any treats? Yes No If yes, what kind? _____
- 5 Has an elimination diet been tried to rule out food allergy? Yes No
- 6 If yes, what diet was used? _____
- 7 How long was it fed? _____ days _____ weeks _____ months
- 8 Was your pet receiving nutritional supplements or flavored heartworm preventative at the same time? Yes No
- 9 Are there other pets in the home? Yes No What type of pets? _____
- 10 Does your pet have ear infections? Yes No
- 11 If yes, was it present prior to the skin disease? Yes No
- 12 What are the primary parts of your pet that he or she spends scratching/itching/chewing/rubbing/licking? _____
- 13 Is the problem seasonal? Yes No
- 14 If yes, what month does it start? _____ What month does it end? _____
- 15 How much time does your pet spend *Indoors*? _____ *Outdoors*? _____
- 16 Is your pet receiving any traditional medical treatment or medication such as antibiotics, steroids, antihistamines, etc. Yes No If yes, please describe: _____
- 17 Is your pet receiving any alternative medical treatment or medication such as acupuncture, chiropractic adjustments, homeopathic or naturopathic herbs? Yes No If so, please describe: _____
- 18 Is there an increase in symptoms while cleaning the house with the pet indoor? Yes No
- 19 Is the itching worse at any specific time of the day or night? Yes No
- 20 How many bowel movements does your pet have daily? _____
- 21 Where does your pet sleep? _____
- 22 What type of material (fabrics, etc.) does the pet sleep on? _____
- 23 Do you have carpet, upholstery or much clothing made of wool material? Yes No
- 24 Does your pet have any known sensitivities to medication or topical (eye and ear ointments/drops skin creams and shampoos) products? Yes No If so, please describe: _____
- 25 Does your pet have any other diagnosed medical problems? Yes No
- 26 Does your house have forced air heating or cooling? Yes No
- 27 Does your pet experience an increase in symptoms during the beginning of the seasons when these appliances are used? Yes No
- 28 Other pertinent information and facts: _____
- 28 REFERRED by: _____