

# Tierdermatologie Deisenhofen : Clinical Consultation



Practice Name: \_\_\_\_\_  
 Contact Vet: \_\_\_\_\_

Animal Name \_\_\_\_\_ Owner \_\_\_\_\_  
 Dog \_\_\_ Cat \_\_\_ Horse \_\_\_ Other \_\_\_\_\_  
 Breed \_\_\_\_\_ Age \_\_\_\_\_  
 F \_\_\_ FS \_\_\_ M \_\_\_ MC \_\_\_

Telephone \_\_\_\_\_  
 Fax \_\_\_\_\_

**Current Problem:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

e-mail \_\_\_\_\_

**History:**

How & when did the dermatosis begin? \_\_\_\_\_

What were the earliest lesions? \_\_\_\_\_

Systemic illness?  no  yes diagnosis \_\_\_\_\_

Previous skin / Ear problems?  no  yes further info: \_\_\_\_\_

Other animals or humans affected?  no  yes further info: \_\_\_\_\_

\*further info.. please supply only the abnormal results with the diagnosis.

**Distribution and type of lesions:**

**Pruritus\*?**  no  yes **Seasonality**  no  yes

Symmetric?  no  yes

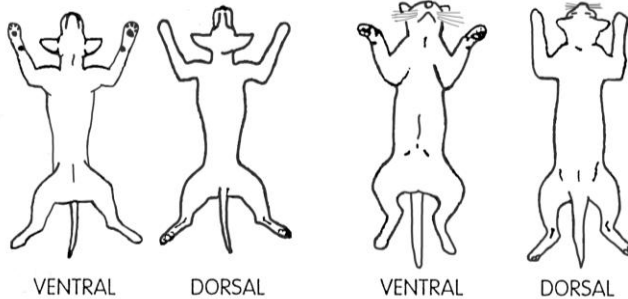
**\*Degree** -please circle:(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

**Localisation:**

Face  Feet  Body  Abdomen  Neck  Ears  Legs  Tail  Flanks  Footpads

Circle affected Areas if that helps:

Please cross the lesions which are present:



- Alopecia
- Callous
- Comedone
- Crusts
- Depigmentation
- Erosion
- Erythema
- Excoriation
- Epidermal collarettes
- Hyperpigmentation
- Lichenification
- Claw changes
- Macules
- Nodules
- Papules
- Plaque
- Pustule
- Scale
- Scar
- Ulcers
- Vesikel
- Other

**Previous diagnostic Tests (please write relevant results briefly):**

Skin scraping	<input type="checkbox"/> no <input type="checkbox"/> yes _____	Serumallergy test	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Cytology	<input type="checkbox"/> no <input type="checkbox"/> yes _____	CBC, serum Biochem	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Bacterial Culture	<input type="checkbox"/> no <input type="checkbox"/> yes _____	Thyroid evaluation?	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Fungal culture	<input type="checkbox"/> no <input type="checkbox"/> yes _____	Cushings evaluation?	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Elimination diet	<input type="checkbox"/> no <input type="checkbox"/> yes _____	Skin Biopsy	<input type="checkbox"/> no <input type="checkbox"/> yes _____
Wood's Lamp	<input type="checkbox"/> no <input type="checkbox"/> yes _____	Other	_____

**Previous Therapy:**

**When yes, please complete the other questions:**

**Please circle:**

Antibiotic	<input type="checkbox"/> no* <input type="checkbox"/> yes	Type _____	Improvement? _____%	#Relapse/Recurrence
Glucocorticoid	<input type="checkbox"/> no <input type="checkbox"/> yes	Type _____	Improvement? _____%	
Shampoo therapy	<input type="checkbox"/> no <input type="checkbox"/> yes	Type _____	Improvement? _____%	
Fleatreatment	<input type="checkbox"/> no <input type="checkbox"/> yes	Type _____	Improvement? _____%	
Mite-therapy	<input type="checkbox"/> no <input type="checkbox"/> yes	Type _____	Improvement? _____%	
Other	_____			

\*AB - No = No (or very limited) improvement in the clinical lesions or pruritus, even during AB treatment

# Relapse/Recurrence = complete remission during therapy BUT : Relapse = return within 2 weeks of therapy end;

Recurrence = return 2 weeks +

**List your clinical differential diagnoses (really important!!!):** \_\_\_\_\_