Animal Allergy
Dermatology Center of Indiana

Patient History Form

Hospital Name:_____

_____

Veterinarian:_____

Phone Number:_____

Fax Number: _____

Email: _____

Owner Name:_____

Owner Phone Number:_____

Patient Name: _____

Breed: _____

Age:_____ Male Female

Spayed or Neutered: Yes No

Description of lesions/problems/reason for referral:

_____

_____

_____

_____

Current or previously recommended therapies:

_____

_____

_____

_____

_____

_____

**Please send this form including lab work, history and any pertinent medical information to:

info@aadci.com or fax to 888-382-4649

Lori Thompson, DVM, DAVCD ● Morgan Mathai, DVM, Veterinary Dermatology Resident

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