Animal Allergy
Dermatology Center of Indiana

Patient History Form

Hospital Name: _____

Veterinarian: _____

Phone Number: _____

Fax Number: _____

Email: _____

Owner Name: _____

Owner Phone Number: _____

Patient Name: _____

Age: _____ Male Female

Breed: _____

Spayed/ Neutered: Yes No

Description of lesions/problems/reason for referral:

_____

_____

_____

_____

Current or previously recommended therapies:

_____

_____

_____

_____

_____

_____

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

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

Lori Thompson, DVM, DACVD

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