Ear Problems

Date: ______________

Patient: ________________________________

Owner: _________________________________

Contact number(s): _______________________ Pick up time: _____________

1. Are one of both ears affected? ____

2. What signs do you see: Circle all that apply

Scratching	Discharge	Swelling	Hearing loss
Shaking head	Odor	Hair loss	Head tilt
Pain	Redness	Sores	

   Other: ____

3. What was the first thing you noticed? _____________________________________

4. When did you first notice a problem? ______________________________________

5. Has it worsened, stayed the same, improved? ______________________________

6. Does your pet swim, get frequent baths and/or frequent grooming? YES NO

7. Has this occurred before? ____

   When? __________________ What was the diagnosis?_______________

   Was it treated? ___________ Was treatment effective? ____________

8. Have you cleaned of treated the ears fir this current problem? YES NO

9. Does your pet have skin or respiratory allergies? YES NO

10. Are and other pets affected? YES NO

11. Are there any concurrent problems? Circle all that apply

Fleas/Ticks	Biting Flies	Itchy skin elsewhere
Lethargy	Loss of appetite	Vomiting

   Other: ____

12. Are diagnostics OK (ear swab cytology) ? YES NO CALL FIRST

Owners Signature: _____________________________