

Pet Allergy Laboratory, Inc. – Equine History Form

Date: _____ Clinic: _____ Veterinarian: _____

Animal's Name: _____ Owner's Name: _____

Animal's Age: _____ Breed: _____ Male Female

Check all symptoms that apply to your horse:

- | | | | |
|---------------------------------------|-----------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Coughing | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Scratching | <input type="checkbox"/> Roaring | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Heaves | <input type="checkbox"/> Odor | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Head Shaking | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Pimples/Acne | <input type="checkbox"/> Other _____ |

Check all areas where your horse has skin problems:

- | | | | | |
|---|------------------------------------|------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Head/Face | <input type="checkbox"/> Eyes | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Withers | <input type="checkbox"/> Barrel | <input type="checkbox"/> Back | <input type="checkbox"/> Loin/Croup | <input type="checkbox"/> Flank |
| <input type="checkbox"/> Hindquarters/Hip | <input type="checkbox"/> Forelimbs | <input type="checkbox"/> Hindlimbs | <input type="checkbox"/> Other _____ | |

At what age did the first symptoms appear? _____

How long have symptoms been occurring? _____

Has the problem spread? Yes No

When are the symptoms worse:

- Winter Spring Summer Fall Not Seasonal

Check all that apply to your horse's environment:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Rural Home | <input type="checkbox"/> Mainly Stabled | <input type="checkbox"/> Travels Often |
| <input type="checkbox"/> City Home | <input type="checkbox"/> Mainly Pastured | <input type="checkbox"/> Other _____ |

Do the symptoms show any correlation with the above environmental factors: Yes No

If Yes, please explain: _____

What variety of foods does your horse eat? (Please check all that apply)

- Hay _____ Grain _____
- Other _____

Has your horse been on a food elimination trial? Yes No If yes, did it help? Yes No

Is your horse on a food elimination trial/diet now? Yes No

If yes, what foods are in the diet? _____

Does your horse have any other conditions or illnesses? _____

To be completed by Veterinarian

Which other diagnostic tools have been used on this patient and what was the result?

- Food Trial _____
- Scrapings _____ Biopsy _____

Which treatments have been used on this patient and what, if any, was the response?

- Steroids _____ Antihistamines _____
- Antibiotics _____ Shampoos/Topicals _____
- Immune Stimulants _____ Desensitization _____
- Holistic Treatments _____

Is the patient currently on Allergy Injections? Yes No

Has this patient been previously allergy tested? Yes No If yes, where? _____

Describe the patient's symptoms: _____