

BeaCon SLO Survey

Name: _____
Address: _____
City, State, Zip or Postal Code: _____
Phone: _____ E-mail: _____

Dogs in household: Beardies _____ Others _____
Other pets in household: _____

Dog

Dog call name: _____ Registered name: _____
Sex: M F Coat Color: _____
Date of Birth (mm/dd/yy): _____
Date of Death (mm/dd/yy): _____
If deceased, cause of death: _____
Sire registered name: _____
Dam registered name: _____
Breeder: _____ Age dog came to live with you: _____

If dog came to live with you later in life and you know anything about his past history, give that info here: _____

Environment

Primary Residence (check appropriate box or give other info).

	Before SLO	Current
House	<input type="checkbox"/>	<input type="checkbox"/>
Kennel	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	_____	_____

Flooring (check box(es) or give other info).

	Before SLO	Current
Carpet	<input type="checkbox"/>	<input type="checkbox"/>
Tile	<input type="checkbox"/>	<input type="checkbox"/>
Linoleum	<input type="checkbox"/>	<input type="checkbox"/>
Wood	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	_____	_____

What outside surface is dog mostly on?

	Before SLO	Current
Grass	<input type="checkbox"/>	<input type="checkbox"/>
Dirt	<input type="checkbox"/>	<input type="checkbox"/>
Concrete	<input type="checkbox"/>	<input type="checkbox"/>
Gravel	<input type="checkbox"/>	<input type="checkbox"/>
Asphalt/tarmac	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	_____	_____

Is your dog frequently in areas populated by a large number of dogs or other animals (e.g., dog parks)? Yes No

If yes, describe area and frequency of visits: _____

Frequency of nail trimming.

	Before SLO	Current
Weekly	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	<input type="checkbox"/>
Other (describe)	_____	_____

Tool used to trim nails (check the one(s) that apply).

Scissor type clippers	<input type="checkbox"/>
Guillotine	<input type="checkbox"/>
Dremel/sander	<input type="checkbox"/>
Don't know (vet or groomer does this)	<input type="checkbox"/>
Other	_____

What do you feed your dog? (check all that apply and give brand)

Commercial kibble	<input type="checkbox"/>	_____
Commercial canned	<input type="checkbox"/>	_____
Commercial raw	<input type="checkbox"/>	_____
Home prepared, raw or cooked	<input type="checkbox"/>	_____
Table scraps	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____
Supplements (not meds for SLO)		_____

Dog Health

Check if your dog has any of these problems.

	Yes	number of times		
Eye infections	<input type="checkbox"/>	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-6	<input type="checkbox"/> >6
Ear infections	<input type="checkbox"/>	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-6	<input type="checkbox"/> >6
Skin infections	<input type="checkbox"/>	<input type="checkbox"/> 1-3	<input type="checkbox"/> 3-6	<input type="checkbox"/> >6
Weepy eyes	<input type="checkbox"/>			
Crusty nose leather	<input type="checkbox"/>			
Food allergies	<input type="checkbox"/>	describe _____		
Atopy*	<input type="checkbox"/>	describe _____		
Other problem requiring regular veterinary care: describe _____				

*Atopy means allergic hypersensitivity to common substances in the environment such as house dust mites or pollens.

Has your dog been diagnosed with an autoimmune disease listed below? Check all that apply.

Addison's disease	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>
AIHA (autoimmune hemolytic anemia)	<input type="checkbox"/>
ITP (idiopathic thrombocytopenia)	<input type="checkbox"/>
Other (describe): _____	

Has your dog has thyroid testing? Yes No

What thyroid testing was done (check closest one or write in others)?

Total T4 only	<input type="checkbox"/>
Free & total T3, T4 and T3, T4 autoantibodies	<input type="checkbox"/>
Free T4 by dialysis, thyroglobulin autoantibodies, canine TSH	<input type="checkbox"/>
Other _____	

What lab was used for thyroid testing? _____

Thyroid testing results (check result): Hypothyroid Normal

Are you aware of any related dogs with an autoimmune disease? Yes No

If yes, what is the relationship to your dog? _____

Check if your dog has any of these behavioral issues.

Aggression, dog

- Aggression, family/owner
- Aggressive, strangers
- Fearful
- Barks excessively for no
apparent reason

Other (describe): _____

Has your dog received medication for the above behavioral issue(s)?

Yes No

Product, dose, duration of treatment: _____

Vaccination History and Preventive Use

Frequency of rabies vaccination.

- Yearly
- Every 3 years
- None given
- Titered
- Other _____

Brand of rabies vaccination if you know. _____

Age of rabies vaccinations.

First: _____

Second: _____

Booster(s): _____

Preventive use – check as appropriate and list Brands.

- Heartworm _____
- Flea/tick, topical _____
- Flea/tick, oral _____
- None _____
- Other (describe) _____

Puppy vaccination history (enter information in table)

Vaccine	Brand	Age

Does your dog receive booster vaccinations?

Yes

No

Titered

Other (describe) _____

What booster vaccinations are given (enter information in table)?

Vaccine	Brand	Frequency
Distemper		
Parvovirus		
Coronavirus		
Lyme		
Giardia		
Leptospirosis		
Bordatella		
Adenovirus 2		
Parainfluenza		
Other		

SLO Related Questions

Age of Onset (range)

Age Range	Check One
<1 yr	<input type="checkbox"/>
1-3 yr	<input type="checkbox"/>
4-7 yr	<input type="checkbox"/>
8-10 yr	<input type="checkbox"/>
>10 yr	<input type="checkbox"/>

Give specific age or date of onset: _____

What were initial signs of a nail problem? (Check all that apply)

Shedding Nails	<input type="checkbox"/>
Brittle claws and soft nails	<input type="checkbox"/>
Malformed nails	<input type="checkbox"/>
Pain	<input type="checkbox"/>
Bleeding nail beds	<input type="checkbox"/>
Loose nails	<input type="checkbox"/>

Other signs: _____

Onset of SLO:

Where were you living if not in the current location? _____

What time of year (or month) did it start? _____

What were your dog's regular activities in the months before onset? _____

Did your dog herd regularly prior to onset? Yes No

After Diagnosis

Were any changes made to your dog's environment? Yes No

If yes, describe changes and whether they had any effect on the problem.

Were any changes made to your dog's diet? Yes No

If yes, describe dietary changes and whether they had any effect on the problem.

Possible Preceding Events

Were vaccines administered within 6 mos? Yes No

If yes, which vaccines and when? _____

Were there any environmental or stressful events preceding the onset? (Check all that apply).

Illness	<input type="checkbox"/>
Rehoming or moving	<input type="checkbox"/>
Heat (weather)	<input type="checkbox"/>
In season	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>
Chemical exposure (lawn, tree spraying, house cleaners, indoor or outdoor pest control, etc.)	<input type="checkbox"/>
Showing or trialing	<input type="checkbox"/>

Describe any other stressors _____

Do you think that any of the above events were sufficiently unusual to have a bearing on the onset of SLO? Yes No

If yes, which one(s) and why? _____

Which claws were involved?

All	<input type="checkbox"/>
Front paws	<input type="checkbox"/>
Rear paws	<input type="checkbox"/>
One paw (which one?)	<input type="checkbox"/>
Dew claws	<input type="checkbox"/>

Has the problem recurred?

Yes No It is ongoing

Are you aware of relatives with a similar problem?

Yes No

If yes, what is their relationship to your dog? _____

May we have consent to contact your dog's breeder in an attempt to gather information about family members (e.g., health, allergic problems, autoimmune problems)?

Yes No

If yes, breeder contact information: _____

Has this dog been used in a breeding program?

Yes No

If yes, has this dog produced one or more pups with SLO?

Yes No

If yes, please elaborate: _____

If yes, has this dog produced one or more pups with any other health problem?

Yes No

If yes, please elaborate: _____

Veterinary care for your dog's nail problem.

What kind of veterinarian(s) directs care of your dog's nail problem? (e.g., if a specialist is guiding the care overseen by your regular vet, the answer would be the discipline of the specialist).

- Generalist
- Dermatologist
- Internal medicine
- Other _____

What are the clinical findings (check all that apply)

Split nails	<input type="checkbox"/>
Infected nails	<input type="checkbox"/>
Abnormal nail growth	<input type="checkbox"/>
Bleeding nails	<input type="checkbox"/>
Nails fall off	<input type="checkbox"/>
Persistent licking at feet/nails	<input type="checkbox"/>
Offensive nail odor	<input type="checkbox"/>
Nail pain	<input type="checkbox"/>
Bleeding nail beds	<input type="checkbox"/>
Lameness	<input type="checkbox"/>

Lab tests performed (check all that apply)

Blood chemistry	<input type="checkbox"/>
Complete blood count	<input type="checkbox"/>
Antinuclear antibody (ANA)	<input type="checkbox"/>
Biopsy – last digit of a toe or dew claw	<input type="checkbox"/>
Biopsy – nail (punch)	<input type="checkbox"/>
Biopsy – skin	<input type="checkbox"/>
Scrapings for fungal culture	<input type="checkbox"/>
Bacterial culture	<input type="checkbox"/>
None	<input type="checkbox"/>
Other (describe on line below)	<input type="checkbox"/>

Other _____

Diagnoses (check all that apply)

SLO (symmetrical lupoid onychodystrophy)	<input type="checkbox"/>
SLE (symmetrical lupus erythematosus)	<input type="checkbox"/>
Pemphigus	<input type="checkbox"/>
Bacterial infection	<input type="checkbox"/>
Fungal infection	<input type="checkbox"/>
Other (describe on line below)	<input type="checkbox"/>

Other _____

What treatments have been given (enter info for all that apply) and what effect (good, some, none) did each have?

Treatment	Dose	Duration	Effect
Fatty acids (derm caps)			
Tetracycline type drugs			
Niacinamide (nicotinamide, vit B3, nicotinic acid amide)			
Vitamin C (ascorbic acid)			
Prednisone type drugs			
Antibiotics			
Antifungals			
Imuran (Azathioprene)			
Cytoxan (cyclophosphamide)			
Pain killers _____			
Other _____ _____			

In what order or combinations were the drugs given? _____

What care is your dog currently receiving?

For you, what were/are the most difficult issues associated with the disease?

Anything else?

Thank you for taking the time and energy to complete this survey.
Please return by email to beaconbb@bellsouth.net or my mail to: Elsa Sell, 764 Liberty Rd.,
Milner, GA 30257

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