ALLERGY, ASTHMA, IMMUNOLOGY OF ROCHESTER, P.C.

CHRONIC URTICARIA (HIVES) QUESTIONNAIRE

Patient Name: _____ Date: _____ DOB: _____

I. General Features

A. Date of onset of hives _____

B. Frequency of attacks (i.e. daily, weekly, etc)

_____

C. Duration of attacks _____

D. Time of day when symptoms most severe

1. mornings _____
2. daytime _____
3. evenings _____
4. after meals _____
5. other _____

E. Parts of body usually affected first, if any

_____

II. Seasonal

Do hives occur more frequently during certain times of the year?

A. Winter _____

B. Cold exposure (wind, swimming, etc.) _____

C. Spring (pollens) _____

D. August-September (ragweed) _____

E. Summer _____

III. Physical

Do any of the following produce hives?

A. Heat exposure _____

B. Exercise _____

C. Sunlight exposure _____

D. Rainy or wet periods _____

E. Damp rooms/areas (molds) _____

F. Bathing or showering _____

G. Pressure, prolonged sitting _____

H. Vibration _____

I. Rubbing or scratching _____

J. Friction, clothing contact _____

Patient Name: _____ DOB: _____

IV. Contact

A. Exposure to animals _____

Which types? _____

B. Exposure to fumes _____

Which types? _____

C. Contact with cosmetics, soaps, detergents, etc.? _____

Which types? _____

V. Hormonal

A. Related to stress _____

B. Menstrual periods _____

C. Pregnancy _____

VI. Occupational-Recreational History

Do hives appear to occur in relation to any of the following? _____

A. Indoors only or predominantly

Rooms/locations in particular

1. Workshop _____
2. Basement _____
3. Attic _____
4. Other _____

B. Outdoors only or predominantly _____

C. At work predominantly _____

D. At home predominantly _____

E. At another location _____

Where? _____

F. During work week predominantly _____

G. On wekends predominantly _____

H. Improve while away on vacation _____

I. Related to recreational activities _____

Which types? _____

J. Occur with housework _____

VII. History of Infections

Have you recently had any of the following infections or symptoms of infection?

A. Sore throat/strep throat _____

B. Swollen lymph glands _____

C. Mononucleosis _____

D. Impetigo/skin infections _____

E. Jaundice/hepatitis _____

Patient Name: _____ DOB: _____

F. Pneumonia _____

G. Yeast Infection _____

H. Painful urination/urinary tract infection _____

I. Infection of gall bladder _____

J. Fungal infection of skin, hair or nails _____

K. Tooth/gum infection _____

L. Other _____

VIII. History of Allergy or Allergic Symptoms

Do you have any of the following types of allergy or allergic symptoms?

A. Hay fever/sinus congestion _____

B. Wheezing/asthma _____

C. Itching of skin _____

D. Eczema _____

E. Excessive tearing _____

F. Nausea/abdominal pains/diarrhea _____

G. Swelling of lips or mouth after eating _____

H. Known allergic agents _____

I. Previous skin testing for allergies _____

J. Family history of above problems _____

IX. Medications

A. List all prescription drugs taken in last year, including those discontinued. Please include any topical (creams) and injected medications.

_____

_____

_____

B. List all over-the-counter drugs taken in the last year. Please include cosmetics in this list.

_____

_____

_____

C. Check list of medications used in last year.

Antibiotics _____

Antidepressants _____

Antihistamines _____

Cortisone _____

Cough medication _____

Decongestants _____

Pain Killers _____

Penicillin _____

Sedatives _____

Seizure medication _____

Sleeping pills _____

Sulfa drugs _____

Patient Name: _____ DOB: _____

Diet pills _____
Digitalis _____
Diuretics _____
Douches _____
Hormones _____
Laxatives _____
Mouth washes _____
Muscle relaxants _____
Oral contraceptives _____
Suppositories _____
Tetracycline _____
Thyroid pills _____
Tonic (quinine) _____
Tranquilizers _____
Vaginal medication _____
Water pills _____
Vitamins _____

D. For which of the following conditions have you taken medication in the last year?

Acne _____
Allergy _____
Anemia _____
Arthritis _____
Asthma _____
Bowel disorder _____
Colds _____
Constipation _____
Cough _____
Depression _____
Diabetes _____
Diarrhea _____
Epilepsy _____
Fungal infection _____
Gall bladder _____
Glaucoma _____
Gout _____
Headaches _____
Heart condition _____
Hemorrhoids _____
Hypertension _____
Indigestion _____
Insomnia _____
Kidney disorder _____
Menopause _____
Menstrual disorder _____
Nervousness _____
Pinworms _____
Rectal disorder _____
Seizures _____
Sinus trouble _____
Thyroid disorder _____
Urinary infection _____
Vaginal infection _____

X. Foods

A. Have you noticed that particular foods cause hives, swelling of lips or tongue, sinus congestion, nausea, abdominal pain or difficulty breathing? Please list foods and accompanying symptoms.

_____

_____

_____

B. Are any of the above symptoms caused by the following foods?

Beer _____
Bread _____
Cake _____
Milk _____
Mints _____
Nuts _____

Patient Name: _____ DOB: _____

Cheese _____	Pickles _____
Cider _____	Sausage _____
Coffee _____	Seafood _____
Eggs _____	Strawberries _____
Grapes _____	Tomatoes _____
Ham/pork _____	Wine _____
Ketchup _____	Vinegar _____

XI. Treatment

Please indicate the treatments that have been used for your hives in the past. Use the following scale to score the response to each type of therapy:

0 - No response ***1 - Slight response*** ***2 - Moderate response*** ***3 - Complete clearing***

Therapy	*Response*
A. Antihistamine	
_____	_____
_____	_____
_____	_____
B. Steroids (oral or injected)	
_____	_____
C. Epinephrine _____	_____
D. Ephedrine _____	_____
E. Dietary elimination-type	
_____	_____
_____	_____
F. Antibiotics	
_____	_____
_____	_____
G. Other - please specify	
_____	_____
_____	_____
_____	_____
_____	_____