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 ______________
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 weekends 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 ________________
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 ________________ Pain Killers ________________
Antidepressants ________________ Penicillin ________________
Antihistamines ________________ Sedatives ________________
Cortisone ________________ Seizure medication ________________
Cough medication ________________ Sleeping pills ________________
Decongestants ________________ Sulfa drugs ________________
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
- 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
- Milk
- Bread
- Mints
- Cake
- Nuts
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

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Response</th>
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<tbody>
<tr>
<td>A. Antihistamine</td>
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<td>B. Steroids (oral or injected)</td>
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<td>C. Epinephrine</td>
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<td>D. Ephedrine</td>
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<td>E. Dietary elimination-type</td>
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<td>F. Antibiotics</td>
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<td>G. Other - please specify</td>
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