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URTICARIA (HIVES) QUESTIONNAIRE

Name: _____ Date: _____
Date of birth: _____ Age: _____
Occupation: _____
Referred by/ PCP: _____

Date this episode of hives first started: _____
How did it start? _____
Did you have hives prior to this episode? □ Yes □ No
If so, when?_____
How long did it last? □ Days □ Weeks □ Months
How was it treated?_____
How often do you break out?
□ Daily □ 3-5 times a week □ Weekly
How long does each individual hive last?
□ Hours □ A day □ A few days
Hives are:
□ Itchy □ Painful □ Burning

Hives are brought on by the following physical stimulation:

□ Cold
□ Exercise
□ Heat
□ Pressure (tight clothing)
□ Scratching skin

Hives are brought on by the following foods:

□ Dried fruits
□ Beer, wine
□ Any pitted fruit (peach, plum, cherry, nectarine)
□ Banana
□ Other:

Hives are brought on by the following medications:

□ Aspirin
□ Ibuprofen (Advil, Motrin)
□ Penicillin (Amoxicillin, Augmentin)
□ Other:

Associated conditions with hives (skin):

□ Joint pain
□ Joint swelling (not just hives over the joints)
□ Swelling: □ Eyes □ Lips □ Other:

Respiratory conditions associated with hives

□ Sneezing, itchy, runny nose
□ Hoarseness
□ Coughing
□ Wheezing

Gastrointestinal conditions associated with hives

□ Itchy mouth
□ Swollen tongue
□ Difficulty swallowing
□ Nausea
□ Vomiting
□ Abdominal pain
□ Diarrhea

List any infections in the 2 months prior to the onset of hives: _____
_____

Family members with hives or swellings lasting for more than 2 months: □Yes □No

List any medications taken in the **LAST** month:

MEDICATIONS	# OF TIMES A DAY	FOR WHAT CONDITIONS

Please list all other illnesses (Past and present)	Date Onset

Please list all hospitalizations and operations:	Date Onset

Female Reproductive: □Surgically sterile □Contraception

Social History:
Smoking/Vaping (circle): # of____packs/day for # of____years
Date quit:_____
□Not applicable
Alcohol: # of drinks per day_____week_____month_____
□Not applicable

Hobbies; What do you do other than work or school?
_____
_____

REVIEW OF SYSTEMS

If not listed above, please check if you've had the following:

General
- □Fever
- □Chills
- □Weight loss____lbs.
- □Weight gain____lbs.
- □Night sweats
- □Fatigue
- □Weakness

Psychology
- □Depression
- □Anxiety/Panic attacks
- □Insomnia or disturbed sleep
- □Wake up unrefreshed
- □High stress level
- □Related to allergy?

Neurologic
- □Migraines
- □Headaches
- □Numbness/tingling
- □Muscle weakness
- □Seizures
- □Difficulty thinking or remembering

Ears
- □Hearing loss
- □Swollen ear
- □Ringing in ears
- □Drainage from ear
- □Vertigo

Skin
- □Hair loss
- □Psoriasis
- □Nail problems
- □Dry skin
- □Eczema

GI/Abdomen
- □Abdominal pain
- □Difficulty swallowing
- □Heartburn
- □Acid Reflux

Endocrine
- □Cold intolerance
- □Heat intolerance
- □Flushing
- □Diabetes
- □Thyroid
  - □High □Low

Genitourinary/Urology
- □Difficulty urinating
- □Cloudy urine
- □Blood in urine
- □Urinary tract infections

Mouth
- □Sores in mouth
- □Dry mouth
- □Dental problems
- □Loss of taste
- □Bleeding gums
- □Sore throat

Heart
- □Chest pain
- □Irregular/rapid heart rate
- □Lightheadedness/ passing out
- □Leg/ankle swelling
- □Leg cramps
- □Heart murmur

Blood/Lymph
- □Swollen lymph nodes
- □Blood clots
- □Bleeding tendency
- □Bruising

Scalp/Head
- □Hair loss
- □Scalp tenderness
- □Jaw pain while chewing