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**URTICARIA QUESTIONNAIRE**

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

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 are 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 \_\_\_\_\_
- K. Ice or Cole \_\_\_\_\_

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 \_\_\_\_\_
  - 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 \_\_\_\_\_  
Where \_\_\_\_\_
- 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 \_\_\_\_\_ has a family member had 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 gallbladder \_\_\_\_\_
- J. Fungal infection of skin, hair, nails, feet \_\_\_\_\_
- 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 the lips or mouth after eating \_\_\_\_\_
- H. Known allergic agents \_\_\_\_\_
- I. Previous skin testing for allergies \_\_\_\_\_
- J. Family history of above problems \_\_\_\_\_

IX. Medications

A. Check list for medications used in the last year.

- |                           |                          |
|---------------------------|--------------------------|
| Antibiotics _____         | Pain Killers _____       |
| Antidepressants _____     | Penicillin _____         |
| Antihistamines _____      | Sedatives _____          |
| Cortisone _____           | Seizure medication _____ |
| Cough medication _____    | Sleeping pills _____     |
| Decongestant _____        | Sulfa drugs _____        |
| Diet pills _____          | Suppositories _____      |
| Digitalis _____           | Tetracycline _____       |
| Diuretics _____           | Thyroid pills _____      |
| Douches _____             | Tonic (quinine) _____    |
| Hormones _____            | Tranquilizers _____      |
| Laxatives _____           | Vaginal medication _____ |
| Mouth washes _____        | Water pills _____        |
| Muscle relaxants _____    | Vitamins _____           |
| Oral contraceptives _____ |                          |

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

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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X. Foods

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

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

Beer _____	Mints _____
Bread _____	NutraSweet _____
Cake _____	Nuts _____
Cheese _____	Pickles _____
Cider _____	Sausage _____
Coffee _____	Seafood _____
Eggs _____	Strawberries _____
Grapes _____	Sulfites _____
Ham / Pork _____	Tomatoes _____
Ketchup _____	Wine _____
Milk _____	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 response

Therapy

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