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URTICARIA (HIVES) / ALLERGY QUESTIONNAIRE

PLEASE DO NOT PLACE YOUR NAME OR DATE OF BIRTH ON THIS FORM

INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about our allergy problem. Please bring this completed form to your first appointment.

1. Please list every medication you are taking or have recently taken, received or used on the used, in the mouth, by suppository, enema, injection, or any other means. Include over the counter medicine, vitamins, and supplements:

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2. Please list any medications in which you have ever been allergic to? ______________

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3. When did your hives start? ______________
4. At the time did you have or do have: a "cold" / gastrointestinal symptoms / new medications / New food eaten or ingested / New personal hygiene item
5. Where are hives located and give approximate size: ______________
6. How long do individual hives last after they appear: ______________
7. Have you had any swelling of lips, mouth, eyes, hands, etc.? ______________
8. Have you ever had hives before? ______________
9. Have you ever had hives from food? If yes, which foods? ______________
10. What do you think might be the current cause? (Put down what you really think even if it might seem unreasonable to someone else.)

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11. **Circle any of the following symptoms that occurred around the time the hives began:**
- Itching
- Burning (Not itching)
- Scaling of area
- Deep swelling
- Target-like bumps
- Asthma
- Fingers painful or white in cold weather
- Bruising
- Trouble breathing
- Pigmentation changes
- Hives in the same place for more than 24 hours
- Blisters

12. **Circle if you have noticed hives or swelling following any of the following activity:**
- Scratching, pressure, or injury to skin
- Water exposure
- Heat exposure
- Cold exposure
- Sun exposure
- Sweating
- Vibration
- Surgery
- Accident or injury
- Other ______________

13. **Have you recently changed or added any new personal hygiene or cleaning products such as:**
- Fabric softener
- Hand soap
- Hair care products
- Make up
- Detergent
- Bath soap
- Perfume
- Eye liner
- Shampoo
- Deodorant
- Lotions
- Other: ______________