SHER ALLERGY SPECIALISTS

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URTICARIA (HIVES) / ALLERGY QUESTIONAIRE

Patient's Name: ______________________________ Date of Birth: ______________________.

INSTRUCTIONS: **Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your 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 which you have ever been allergic ______________________________

3. When did your hives start?______________________________

4. At that 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 THEN 24 HOURS
- BLISTERS

12. CIRCLE IF YOU HAVE NOTICED HIVES OR SWELLING FOLOWING ANY OF THE FOLLOWING ACTIVITY:

- SCRATHCING, 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 SOFTNER
- HAND SOAP
- HAIR CARE PRODUCTS
- MAKE-UP
- DETERGENT
- BATH SOAP
- PERFUME
- EYE-LINER
- SHAMPOO
- DEODERANT
- LOTIONS
- OTHER:______________ ____________________