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:

_____

_____

_____

_____

_____

_____

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.) _____

11. CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT OCCURRED AROUND THE TIME THE HIVES BEGAN:

ITCHING
BURNING (NOT ITCHING)
HIVES IN THE SAME PLACE FOR MORE THEN 24 HOURS
SCALING OF AREA
DEEP SWELLING
TARGET-LIKE BUMPS
ASTHMA
FINGERS PAINFUL OR WHITE IN COLD WEATHER
BRUISING
TROUBLE BREATHING
PIGMENTATION CHANGES
BLISTERS

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

SCRATCHING, PRESSURE OR INJURY TO SKIN
EXPOSURE TO WATER
EXPOSURE TO HEAT
SWEATING (HEAT, BATH, EXERCISE, ETC.)
EXPOSURE TO COLD
SUN EXPOSURE
INJURY, SURGERY OR AN ACCIDENT
VIBRATION
OTHER: _____

13. HAVE YOU RECENTLY CHANGED OR ADDED ANY NEW PERSONAL HYGINE OR CLEANING PRODUCTS SUCH AS:

FABRIC SOFTNER	HAND SOAP	HAIR CARE PRODUCTS	MAKE-UP
DETERGENT	BATH SOAP	PERFUME	EYE-LINER
SHAMPOO	DEODERANT	LOTIONS	OTHER:_____

14. PROBLEMS: Have you ever had the following problems or conditions?

Yes	Check all items that apply	Age at onset	Severity Mild, Moderate or Severe	
	Asthma			
	Any other breathing problems			
	Sinus trouble			
	Hay Fever (Nasal Allergies)			
	Eczema or other rashes			
	Frequent infections			
	Insect reactions			
	Latex Allergy			
	Metal Allergy			

15. SYMPTOMS: Are you having any of the following? Circle all that apply and indicate frequency

NASAL & SINUS (indicate frequency)
Runny Nose (One side vs both)
Stuffy Nose (One side vs both)
Discolored nasal drainage
Post Nasal Drip
Itchy Nose
Sneezing
Throat clearing
Cough
Hoarseness
Bad Breath
Sore throat
Nose Bleeds
Nasal Polyps
Loss or Decrease Sense of Smell
Mouth Breathing/Snoring
Sleep Apnea (stop breathing during sleep)
Sinus X-Rays
Head or Sinus CT Scan

EYES (indicate frequency)
Itching
Redness
Watery
Dark Circles
Dry eyes

CHEST (indicate frequency)
Cough with Exercise
Cough with Laughter
Cough middle of night
Cough Lying Down
Cough upon awakening
Shortness of Breath
Wheezing
Chest Tightness
Nighttime Waking
Heartburn
Acid Reflux
Chest Pain
Chest X-ray

SKIN (indicate frequency)
Rash
Swelling
Itching
Bruising
Dry Skin
Eczema

INFECTIONS (indicate frequency)
Ear Infections
Throat Infections
Sinus Infections
Pneumonia
Bronchitis
Other Infections

HEADACHES
Frequent headaches
Severity _____
Triggers _____
Pressure
Unilateral
Bilateral
Visual Disturbances
Nausea
Vomiting

Are symptoms present year round? _____

Is there a time of year that symptoms are worse?_____

16. RESIDENCE: List your past residents with your most recent first. List only city and state.

	City & State	How Long	Symptoms better	Symptoms worse	No Change
1.					
2.					
3.					

17. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had allergy skin tests? ☐ Yes ☐ No If yes, date (How long ago) _____ Physician's Name:_____

What were the results of these tests: _____

Have you ever received allergy shots? ☐ Yes ☐ No If yes, give dates: _____

Did your symptoms improve while you received shots? ☐ Yes ☐ No

Did you ever experience an adverse reaction to an allergy injection? ☐ Yes ☐ No

If yes, please specify:_____

18. OTHER MEDICAL PROBLEMS: Have you ever been diagnosed with or had any of the following? Circle all that apply

Hearing Loss
Glaucoma
Glasses
Diabetes
Coughed up blood
Tuberculosis
Heart Trouble
High Blood Pressure
Hepatitis or Liver Trouble
Frequent Heartburn
Frequent Diarrhea
Frequent Constipation
Bedwetting
Arthritis
Fatigue
Kidney or Bladder Trouble
Disruptive Sleep
Fever
Chills / Sweats
Sensitivity to Sun
Poison Ivy
Poison Oak
Other:_____
_____

19. WEIGHT: Weight now:_____ Weight one year ago:_____ Maximum weight: _____When?_____

20. IMMUNIZATIONS: Have you ever experienced any adverse reactions to any immunizations? List dates and reactions, if any.

Tetanus Booster_____ Influenza _____

Pneumovax_____ MMR _____

HIB_____ Prevnar_____

21. BIRTH HISTORY: Please complete the following:

Place of Birth:_____ Age of mother at birth:_____

Was pregnancy normal: ☐ Yes ☐ No If no, please specify reason: _____

_____

Was delivery by: ☐ C-Section ☐ Vaginal Patient was: ☐ Formula fed ☐ breast fed

In the first year of life were any of the following present? ☐ Colic ☐ Spit up a lot ☐ Rash ☐ Eczema

Was patient born with pets present in the home? ☐ Yes ☐ No (If Yes, please list): _____

22. HOSPITALIZATIONS: Please list any surgeries or medical conditions for which you have been hospitalized. (also list dates and doctors)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

23. MARITAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children:_____

24. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed?_____

Is your work environment: ☐carpeted ☐ tiled Are you exposed to chemicals or strong odors or anything that might aggravate your condition?

If yes, please specify: _____

Are you exposed to smoke? ☐ Yes ☐ No Are your symptoms worse at work? If yes please specify:_____

Have you missed work because of your allergies? _____ How many days in the last year? _____

25. SCHOOL ENVIRONMENT:

What school do you attend? _____ Is your classroom: ☐ carpeted ☐ tiled

Is there a problem with mold or mildew? _____

Have you missed school because of your allergies? _____ How many days in the last year? _____

Do you feel school performance has been affected by allergies? _____

26. FAMILY HISTORY: Do any members of your family have a history of allergy?

	Yes	No	(If Yes): List Relationship
Asthma	☐	☐	
Hay Fever	☐	☐	
Eczema	☐	☐	
Hives	☐	☐	
Swelling	☐	☐	
Pneumonia	☐	☐	
Headaches	☐	☐	
Emphysema	☐	☐	
Lung Disease	☐	☐	

	Yes	No	(If Yes): List Relationship
Cystic Fibrosis	☐	☐	
Tuberculosis	☐	☐	
Thyroid Disease	☐	☐	
Glaucoma	☐	☐	
Diabetes	☐	☐	

Other: Please Specify_____

_____

27. ENVIRONMENTAL SURVEY:

Where do you live? ☐City ☐ Rural	Is the home: ☐ carpeted ☐ tiled Is bedroom: ☐ carpeted ☐ tiled
House construction (brick wood etc.):	How old is your _____pillow? _____Mattress?
Approximate age of house:	Is your pillow: ☐ feather ☐ foam rubber ☐ Dacron ☐ encased in plastic ☐ other:
Are any rooms damp or musty?	Is your mattress: ☐ innerspring ☐ foam rubber ☐ Waterbed ☐ encased in plastic ☐ other:
Type of air conditioning? (central, wall unit etc.):	Are your sheets washed in: ☐ cold ☐ warm ☐ hot water
Type of heating? (electric, gas, central, etc.)	Do you have any: ☐ Stuffed furniture ☐ Feather comforters ☐ stuffed animals
Do you have: ☐ Air Cleaner ☐ Air dehumidifier	Do you have pets? (List number and kind. dog, cats, birds, horses etc):
How often do you change/clean your air conditioner and air cleaner filters?	
Number of indoor plants in the home:	Do your pets spend time indoors?
What kind of grass, shrubs and trees are around the home? List:	Other:

28. SELF EVALUATION:

How would you best describe yourself or child?

Timid	Tense
Quiet	Calm
Forward	Few Friends
Aggressive	Well adjusted
Unfriendly	Spoiled
Introvert	Dependent
Independent	Manipulative
Extroverted	Usually ill
Relaxed	Concerned
Happy	Anxious
Many Friends	Shy

29. SMOKING / ALCHOHOL / CAFFEINE USE:

Have you ever smoked? ☐Yes ☐ No If yes, how many years?_____ Do you presently smoke? ☐Yes ☐ No

If no, when did you stop_____ Average cigarettes per day at highest point?_____

If you still smoke, do you think you could stop? ☐Yes ☐ No Do you or family members smoke ☐ In the house ☐ In the car

Which other family members now smoke?_____

Do you drink alcohol ☐Yes ☐ No If yes, list type:_____

Average weekly consumption (times per week):_____

Do you consume caffeine? ☐Yes ☐ No Any other Drug use? ☐Yes ☐ No If Yes, Explain:_____