Hives History Questionnaire

GENERAL

When did your hives first begin?

What were you doing when you had your first episode ?

Are your hives: ☐ Getting worse or ☐ Occurring more often

How often are you having hives now?

What day of the week does your hives usually occur? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

What time of the day do your hives usually occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

When your hives break out, how many hours do they usually last?

Where on your body do your hives usually break out?

What size are your hives when they first break out?

After they break out, do they proceed to get larger in size?

What is the physical appearance of your hives? ☐ Circular ☐ Thready ☐ Gyrate ☐ Irregular

Do your hives: ☐ Itch? ☐ Burn? ☐ Sting?

Do you have episodes of swelling which involves parts of your body? ☐ Yes ☐ No
☐ Face ☐ Eyelids ☐ Lips ☐ Hands ☐ Feet ☐ Other: ______________________________

Does minor trauma to your skin cause it to become numb and then swell? ☐ Yes ☐ No

When you have hives, do you have any of the following symptoms?
☐ Headache ☐ Listlessness ☐ Flushing ☐ Hoarseness ☐ Chest Tightness ☐ Stomach Upset
☐ Faintness ☐ Swelling ☐ Palpitations ☐ Diarrhea ☐ Throat Tightness ☐ Stomach Cramps

Medications: (list all medications you have used for your hives)

Do they provide good relief for your itching and hives? ☐ Yes ☐ No

LOCATION (check the location where your hives break out most often?
☐ indoors ☐ outdoors ☐ at home ☐ at work ☐ at school ☐ on vacation ☐ occurs at any location

Is there a more specific location (i.e. bedroom, etc) where your hives break out more often? ☐ Yes ☐ No
Where: ____

Activities: Have you developed hives during nay of these activities?
☐ during play, hobbies, swimming, golfing, boating, fishing,etc. ☐ bathing ☐ cooking ☐ painting ☐ doing laundry
☐ cleaning house ☐ working in the yard ☐ Other:______________________

POSSIBLE CONTRIBUTING FACTORS

Known factors(list any thing that you know which will cause you to have hives, swelling, or cause your skin to itch):

Skin Factors

Do you have a tendency for very "itchy" skin? ☐ Yes ☐ No

Are your hives present before you scratch your skin? ☐ Yes ☐ No

Have you ever had trouble with eczema? ☐ Yes ☐ No | What ages?

Do you have any other chronic skin rashes? ☐ Yes ☐ No

Dermographism

Do you get a hive after scratching your skin? ☐ Yes ☐ No

Are your hives present before you scratch your skin? ☐ Yes ☐ No

Do your hives occur only after you scratch your skin? ☐ Yes ☐ No

Do your hives occur where pressure is constantly applied to your skin such as under belt, elastic straps, etc? ☐ Yes ☐ No

Do any of these factors cause your hives to start? ☐ Heat ☐ Hot baths ☐ Sweating ☐ Exercise ☐ Hot foods
☐ Hot beverages ☐ Being angry ☐ Excitement

Psychogenic

With your first episode of hives, did they occur during a particular emotionally stressful situation? ☐ **Yes** ☐ **No**

Inhalants

Do you frequently have any of the following symptoms? ☐ Itchy red eyes ☐ Itchy nose ☐ Frequent sneezing ☐ Coughing ☐ Wheezing ☐ Stuffy, running nose

Will any of the following cause the above symptoms of your hives to occur? ☐ A walk through the woods or open ☐ Mowing the grass ☐ Raking leaves ☐ Being around plants, flowers ☐ Exposure to house dust ☐ Hay, fiber, chalk, or wood dust ☐ Being in a damp musty area

Are your hives worse during any particular season or weather condition?

SEASONS		WEATHER		
☐ Spring	☐ Fall	☐ Rainy	☐ Hot	☐ Humid
☐ Summer	☐ Winter	☐ Cloudy	☐ Cold	☐ Dry

Will odors from any of the following cause you to have hives? ☐ Household chemicals, sprays, solvents ☐ Paint fumes ☐ Insecticides ☐ Tobacco smoke ☐ Sprays, deodorants ☐ Lotions, powders ☐ Any plants ☐ Shampoos, etc. ☐ Cooking food ☐ Other(Please list): ____________________

Foods

Have you ever broken out with hives while preparing or eating a meal, or soon thereafter? ☐ Yes ☐ No

Do any of these symptoms occur after eating a meal or particular food? ☐ Itching of the mouth ☐ A skin rash ☐ Runny nose ☐ Wheezing ☐ Stomach cramps ☐ Diarrhea

What foods or beverages caused the symptoms that you checked?

Has eating any of the following items caused you to have hives or itching? ☐ Milk ☐ Eggs ☐ Cereal ☐ Citrus Fruit ☐ Nuts ☐ Chocolate ☐ Any meats ☐ Berries ☐ Seafood ☐ Corn syrup ☐ Beer ☐ Wine ☐ Kool-Aide

Do you suspect any other food or beverages as a cause of your hives? ☐ Yes ☐ No

What are they?

Have you ever had an allergy or intolerance to milk or milk products (even as an infant or a child)? ☐ Yes ☐ No

Do you refuse to eat any particular food(s)? ☐ Yes ☐ No | What food(s)?

Do you eat or drink a large amount of any particular food(s) or beverage(s)? ☐ Yes ☐ No | What food(s)? | What beverage(s)?

Have you eliminated foods from your diet? ☐ Yes ☐ No | What food(s)?

Did this cause your hives to decrease in severity? ☐ Yes ☐ No

INFECTIONS

Did your hives seem to start soon after you had an infection (flu, tonsils)? ☐ Yes ☐ No

When you have hives, do you usually have a fever? ☐ Yes ☐ No

Do you frequently have any of the following infections?

☐ Recurrent fever	☐ Frequent cough	☐ Post nasal discharge	☐ Chronic sore throat
☐ Night Sweats	☐ Vaginal discharge	☐ Toothache	☐ Bleeding, tender gums
☐ Loss of weight	☐ Recurrent diarrhea	☐ Cough up blood	☐ Swollen lymph nodes
☐ Stomach Trouble	☐ Mucous in stools	☐ Burning urination	☐ Headaches
☐ Genital itching			

Do you frequently have any of the following infections?

☐ Frequent tonsillitis	☐ Frequent skin infections	☐ Fever blisters	☐ Kidney infections
☐ Frequent ear infections	☐ Pneumonia	☐ Fungus infections	☐ Prostate infections
☐ Sinus infections	☐ Dental infections	☐ Gall bladder infection	☐ Vaginal infections

List any infection(s) you have had in the past several months:

Drugs & Vaccines

Did your hives seem to start with or soon after you completed a course of medication(s) for any illness? ☐ Yes ☐ No

List any medications, not already listed, that you are taking:

Does taking aspirin or codeine cause you to have any of the following symptoms? ☐ Flushing ☐ Itching ☐ Sweating ☐ Swelling ☐ Hives ☐ Wheezing ☐ Other (Please List):____________________

List the drugs, antibiotics (penicillin), or immunizations to which you may be allergic. Check the reaction that you had to each one.

Medication:	☐ Rash ☐ Fever ☐ Hives ☐ Itching ☐ Swollen arms ☐ Muscle aches
Medication:	☐ Rash ☐ Fever ☐ Hives ☐ Itching ☐ Swollen arms ☐ Muscle aches
Medication:	☐ Rash ☐ Fever ☐ Hives ☐ Itching ☐ Swollen arms ☐ Muscle aches
Medication:	☐ Rash ☐ Fever ☐ Hives ☐ Itching ☐ Swollen arms ☐ Muscle aches
Medication:	☐ Rash ☐ Fever ☐ Hives ☐ Itching ☐ Swollen arms ☐ Muscle aches

Have you ever had x-rays of your kidneys, gall-bladder, or spine where a dye was injected? ☐ Yes ☐ No

ENVIRONMENTAL SURVEY (check the items that are present in your home)

☐Rugs, rug pad	☐Fiberglass curtains	☐Wool blankets	☐Central heating (gas or heating)
☐Wool or animal hair	☐Feather pillows	☐Stuffed animals	☐Other type of heating (list):
☐Over stuffed furniture	☐Kapok cushions	☐House plants	

Is there anything in your house? ☐ Stuffed real animals ☐ Furniture of aromatic woods ☐ Items from foreign countries

List any animals or birds that you have or frequently come into contact with:

Is there anything in your building, yard, or around your house that you think may cause you to have hives? ☐ Yes ☐ No

List:

Personal Social History

What is your occupation?

At work or school do you come into contact with any of the following: ☐ Dust ☐ Smoke ☐ Chemicals ☐ Fumes ☐ Animals ☐ Air pollution

What hobbies do you have?

Do you smoke cigarettes? ☐ Yes ☐ No	How many?	What brand?
Do you drink alcoholic beverages? ☐ Yes ☐ No	How often?	

Family History

Does any other family member have recurrent hives and/or swelling of face, lips, or other parts of their body? ☐ Yes ☐ No

Do any of these illnesses run on your father or mother's side of the family: ☐ Asthma/ hay fever ☐ Emphysema ☐ Arthritis ☐ Individuals with frequent infections ☐ Thyroid trouble

Past Medical History

List any illnesses or disorders that you have had:

List any surgery that you have had:

List any injuries that you have had:

Contactants: Do you know of anything with which you come into contact with that will cause you to itch, or to develop a rash or hives? ☐ Yes ☐ No

List:

List by name all of the items (as listed below) that you use:

Hair shampoos, conditioners:

Bath soaps, oils, soaks:

Facial cleansers, cosmetics:

Toothpaste:	Mouthwash:	Deodorant:	Detergents:

Body perfumes, lotions, creams:	Fabric Softener:	Fabric Whitener:

Do you frequently come into contact with any of the following items? ☐ Moth balls ☐ Fresh paint ☐ Silk
☐ Insecticides ☐ Fiberglass ☐ Household Chemicals ☐ Fertilizers

Physical Factors

Do any of the following factors cause you to develop a rash or hives, or cause your skin to swell, itch, or burn? ☐ Water
☐ Cold Objects ☐ Cold Air ☐ From Cold to Water ☐ Heat
☐ Cold Water ☐ Change in Temperature ☐ Air conditioning ☐ Sunlight

Systemic

Since your hives began, have you had any of these symptoms?
☐ Frequent fever ☐ Anemia ☐ Swollen lymph nodes ☐ Purple spots on skin ☐ Blood, protein, or pus in urine
☐ Loss of Weight ☐ Bruise easily ☐ Cold, clammy fingers ☐ Brown spots on skin ☐ Joint stiffness
☐ Loss of energy ☐ Chronic eczema ☐ Muscle tenderness

Endocrine

Do you have any of the following problems?
☐ Intolerance to heat or cold ☐ Change in texture of skin or hair ☐ Thyroid trouble ☐ Diabetes

Insects

Have you ever had hives after an insect bite or sting? ☐ Yes ☐ No
Does contact with moths or other insects cause you to have hives? ☐ Yes ☐ No

Women

Are your menstrual periods regular? ☐ Yes ☐ No
Are your hives worse before or during your menstrual periods? ☐ Yes ☐ No ☐ N/A
Were your hives affected when you were pregnant? ☐ Yes ☐ No ☐ N/A

Patient Name: DOB: SSN:

Patient Signature: Date: