HIVES/SWELLING PATIENT HISTORY

Allergy/Asthma Specialists W. MI
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Patient Name: _____
DATE COMPLETED: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS *as best as you can*. You can clarify issues further during your visit with the doctor.

1) About when did your symptoms **begin**?: *(approximate)* _____
   a) Have you had a previous problem with hives and/or swelling? YES / NO
   b) IF YES, when did it previously begin and how long did it last? _____
2) **DESCRIPTION** of rash*(please circle)* : itchy burning painful raised flat like a mosquito bite fluid filled blister blotchy circular donut shaped welts red flaking small bumps other:_____
3) **SIZE** *(circle any)*: tiny bumps finger tip size penny size quarter size palm size other*(various sizes)*:_____
4) Any **swelling** episodes? YES / NO *(please circle)* : upper lip lower lip both lips face hands feet tongue other:_____
5) TYPICALLY, about **how long** does a **single patch** last on the skin? *(circle or fill in)* : _____ minutes _____ hours but less than 24 hours 1-2 days several days
6) How **often** do you have hives/rash? *(please circle or fill in)* daily _____ days/week _____ times/month other_____
7) **Where** have you had the hives/rash?: head to toe face neck arms legs belly back all over other_____
8) Any **discoloration** of the skin after the rash resolves (like bruising)? YES / NO
9) Worse any **time of day**?: morning afternoon evening night anytime
10) Was there any **other illness** or event associated with the beginning of your condition? (example: cold with fever, penicillin reaction) *(please describe)* _____
11) Any **other symptoms associated** with hives and/or swelling? *(please circle)* fevers shakes chills joint problems arthritis weight changes breathing problems stomach problems urine changes (blood, dark tea colored)
12) Anything make it **better?** ***(including over the counter medications)***: _____
_____.
13) Did you require any **Emergency treatment** for the hives and/ or swelling? YES / NO
   a) Do you recall the medications used, and the response? _____
_____

PLEASE COMPLETE OTHER SIDE →

14) **Any suspected TRIGGERS?**: (*circle those that **cause or worsen** your hives/ swelling)*

i) Scratching? YES / NO

ii) Any new soaps / shampoos / detergents? _____

iii) Anything new in your diet? *(If yes, what do you suspect?)*_____

iv) Medications, including over the counter (especially Aspirin/Motrin/blood pressure medications)*(specify)* _____

v) Cold ?_____Heat? (hot showers, hot tubs, saunas, etc) _____

vi) Exercise?_____

vii) Anything new in your home or work environment?_____

viii) Contact with animals, insects, plants, chemicals, hobbies *(specify)* _____

ix) Stress?(personal, family, work, school)_____

x) Other *(specify)* _____

15) Are you allergic to latex (rubber)? YES / NO

a) If yes, what kind of reaction?: _____

16) Any history of thyroid problems? YES / NO

17) Any history of arthritis? YES / NO

18) Occupation? *(descriptive)* _____

19) List all current medications. (include skin preparations, aspirin, vitamins, birth control)

a. _____ e._____

b._____ f. _____

c._____ g. _____

d. _____ h. _____

20) Have you ever seen a dermatologist? YES / NO

21) Have you had any blood work or other testing done because of the hives/swelling/rash? YES / NO

THANK YOU!!!

If you cannot stop antihistamines before your appointment because of hives, then just continue them and we will discuss whether or not skin testing will be needed or consider other options.