

ALLERGY & ASTHMA CENTER OF NE OHIO, INC.
HIVES QUESTIONNAIRE:

When did your hives first start? Date _____

Describe the circumstances when your hives started: (fever, sore throat, etc.)

Do you get any days free of hives? Yes _____ No _____

How often do you get hives: daily _____ weekly _____ monthly _____

Do you get any swelling, like swollen hands, feet: Yes _____ No _____

Do you get any lip or tongue swelling? Yes _____ No _____

Do you get joint pain or redness? Yes _____ No _____

Do you get nausea, vomiting or diarrhea with hives? Yes _____ No _____

Any weight loss with the hives? Yes _____ No _____

Any unexplained, prolonged or episodic fevers? Yes _____ No _____

Any heat or cold intolerance? Yes _____ No _____

Any weakness or fatigue with hives? Yes _____ No _____

Do your hives itch? Yes _____ No _____

Please **circle** all that apply: Are your hives: **flat?** **Raised?** **Red?** **Pink?** **Purple?**

Do your hives leave any bruise marks after they're gone? Yes _____ No _____

Does any one body part get more hives than another? Yes _____ No _____

If yes, where? _____

Is there any specific time that the hives are particularly difficult?

Morning _____ Night _____ Other _____

Is there a family history of hives? Yes _____ No _____

Do you think there is a trigger for hives:

Foods? Yes _____ (which ones? _____) No _____

How soon after you eat do the hives begin? _____

Medications? Yes _____ (which ones? _____) No _____

Activities: exercise? Yes _____ No _____

Hot showers? Yes _____ No _____

Cold water? Yes _____ No _____

Do you take any medications either prescribed or non-prescribed or over the counter or supplements?

If yes please list them and approximate date started:
