

ALLERGY, ASTHMA & CLINICAL IMMUNOLOGY ASSOCIATES

Diplomates of The American Board of Allergy and Immunology
(A Conjoint Board of The American Boards of Internal Medicine and Pediatrics)

Pinkus Goldberg, M.D.

Douglas J. Horton, M.D.

Steven L. Wise, M.D.

John E. Duplantier, M.D.

PATIENT QUESTIONNAIRE FOR HIVES

(Please check all yes and no squares)

| | | YES | NO |
|---|----|--------------------------|--------------------------|
| 1. How long have you had your hives: | | | |
| a. Only a few days | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. More than a week | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. More than a month | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. More than six (6) months | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. More than one (1) year | e. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you broken out: | | | |
| a. All the time | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Only once in awhile | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Only at night | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. If your hives come and go, do they last: | | | |
| a. For long periods | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. For just a short time | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do your hives appear: | | | |
| a. The same time each day | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The same time each week | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The same time each month | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The same time each year | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. At no regular time | e. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is your breaking out: | | | |
| a. All over your body | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Just in scattered spots | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Always in the same place on your skin | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do your hives appear only when you rub or scratch? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are the hives you get: | | | |
| a. Small | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Large | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Very Large | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you break out only while at work? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do your hives disappear: | | | |
| a. When you are away from your work | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. When you are away from home for a time | b. | <input type="checkbox"/> | <input type="checkbox"/> |

| | | YES | NO |
|--|----|--------------------------|--------------------------|
| 10. Do any of the following things make your hives worse: | | | |
| a. Heat | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Exertion | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cold | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Sunlight | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pressure on your skin | e. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Rubbing | f. | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Nervous tension | g. | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Getting tired | h. | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Bathing or swimming | i. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Eating | j. | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Breathing dusts | k. | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Breathing vapors | l. | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Sprays | m. | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Green plants or flowers | n. | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Animals | o. | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Tooth brushing | p. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you been getting, taking, or using the following in the past eight (8) weeks: | | | |
| a. Aspirin | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Headache remedies | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pain killers | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Laxatives | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Prescription medicines | e. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Rest medicines | f. | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Tranquilizers | g. | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Vitamins | h. | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Tonics | i. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Nose, eye, or ear drops or sprays | j. | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Hormones | k. | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Birth control pills | l. | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Any ointments, salves, lotions, or liniments | m. | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Body or bath powders | n. | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Artificial sweeteners | o. | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Regular injections from your doctor | p. | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Hemorrhoid medicines | q. | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Nerve medicines | r. | <input type="checkbox"/> | <input type="checkbox"/> |
| s. Reducing pills | s. | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Penicillin | t. | <input type="checkbox"/> | <input type="checkbox"/> |
| u. Sulfa | u. | <input type="checkbox"/> | <input type="checkbox"/> |
| v. Suppositories | v. | <input type="checkbox"/> | <input type="checkbox"/> |
| w. Tetanus shots | w. | <input type="checkbox"/> | <input type="checkbox"/> |
| x. Allergy shots | x. | <input type="checkbox"/> | <input type="checkbox"/> |
| y. Quinine water | y. | <input type="checkbox"/> | <input type="checkbox"/> |
| z. Mouthwash | z. | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you been on a vacation or outing in the last month? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been out of the United States in the last year? | | <input type="checkbox"/> | <input type="checkbox"/> |

| | YES | NO |
|---|-----------------------------|--------------------------|
| 14. Are you regularly exposed to: | | |
| a. Cattle | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. Horses | b. <input type="checkbox"/> | <input type="checkbox"/> |
| c. Sheep | c. <input type="checkbox"/> | <input type="checkbox"/> |
| d. Goats | d. <input type="checkbox"/> | <input type="checkbox"/> |
| e. Dogs | e. <input type="checkbox"/> | <input type="checkbox"/> |
| f. Cats | f. <input type="checkbox"/> | <input type="checkbox"/> |
| g. Fowl | g. <input type="checkbox"/> | <input type="checkbox"/> |
| h. Birds | h. <input type="checkbox"/> | <input type="checkbox"/> |
| i. Rabbits | i. <input type="checkbox"/> | <input type="checkbox"/> |
| j. Other animals | j. <input type="checkbox"/> | <input type="checkbox"/> |
| k. Feathers | k. <input type="checkbox"/> | <input type="checkbox"/> |
| l. Packing material | l. <input type="checkbox"/> | <input type="checkbox"/> |
| m. Insects | m. <input type="checkbox"/> | <input type="checkbox"/> |
| n. Caterpillars | n. <input type="checkbox"/> | <input type="checkbox"/> |
| o. Bath oils | o. <input type="checkbox"/> | <input type="checkbox"/> |
| p. Bubble bath | p. <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you use: | | |
| a. Cigarettes | a. <input type="checkbox"/> | <input type="checkbox"/> |
| b. Mentholated cigarettes | b. <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cigars | c. <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chewing tobacco | d. <input type="checkbox"/> | <input type="checkbox"/> |
| e. Snuff | e. <input type="checkbox"/> | <input type="checkbox"/> |
| f. Mints | f. <input type="checkbox"/> | <input type="checkbox"/> |
| g. Chewing gum | g. <input type="checkbox"/> | <input type="checkbox"/> |
| h. Breath fresheners | h. <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you been in the hospital in the last eight (8) weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had any surgery in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any blood transfusions in the last few months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you had any special kidney, liver or heart testing done in the last few months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had any dental work in the last two (2) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you had any recent immunizing injections, such as for measles, typhoid, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you been exposed to anyone else with an itchy rash? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you recently moved to a different house or apartment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you have any scaling, redness or breaking out on your feet, ankles, or groin area? | <input type="checkbox"/> | <input type="checkbox"/> |

| | | YES | NO |
|---|----|--------------------------|--------------------------|
| 25. Do you have or use: | | | |
| a. Water softener | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Well water | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Water from a creek or stream | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Bottled water | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have any surgeons ever put pieces of metal or wire in any of your joints, skull, or other parts of your body? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you wear any metal dental appliances? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you wear a heart pacemaker? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do any of your blood relatives have hives? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have any of the following: | | | |
| a. Infected teeth or gums | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Infected tonsils | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Infected gallbladder | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Infected kidneys | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Troubles with urination | e. | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Painful | 1. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dark colored urine | 2. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Female infection of any kind | f. | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Prostrate infection | g. | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Infected sinuses | h. | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Lung infection | i. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ear infection | j. | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Bowel trouble | k. | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Tapeworm at any time | 1. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Abnormal bowel movements | 2. | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Too loose | a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Constipation | b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Very dark colored stools | c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Very light colored stools | d. | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Stomach pain or cramps | l. | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Regular spells of fever | m. | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Swollen joints | n. | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Muscle weakness | o. | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Swollen glands | p. | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Any large swelling of any kind | q. | <input type="checkbox"/> | <input type="checkbox"/> |
| r. Persistent cough | r. | <input type="checkbox"/> | <input type="checkbox"/> |
| s. Chest pain | s. | <input type="checkbox"/> | <input type="checkbox"/> |
| t. Painful breathing | t. | <input type="checkbox"/> | <input type="checkbox"/> |
| u. Circulation trouble with hands or feet | u. | <input type="checkbox"/> | <input type="checkbox"/> |
| v. Hay fever | v. | <input type="checkbox"/> | <input type="checkbox"/> |
| w. Asthma | w. | <input type="checkbox"/> | <input type="checkbox"/> |
| x. Frequent cold sores or fever blisters | x. | <input type="checkbox"/> | <input type="checkbox"/> |