

**ALLERGY, ASTHMA & CLINICAL
IMMUNOLOGY ASSOCIATES
ALLERGY ASSOCIATES OF CENTRAL INDIANA**

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

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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"/>