Allergy & Immunology
130 W. Exchange St.
Akron OH 44302
Ph: 330-543-0140
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Hives Questionnaire

Patient name:_____Birthdate:_____

When did your hives first start? _____month _____year

Describe the circumstances when your hives started? [Fever, sore throat, etc.]

_____

Did you have contact with anything unusual? If yes, describe:

_____

Do you get any days free of hives? If yes, describe:

_____

How often do the hives occur ☐ daily ☐ weekly ☐ other_____

Do you get any swelling? (hands, feet) If yes, describe:

_____

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

Do your hives itch? ☐ Yes ☐ No

What do your hives look like? [check all that apply] ☐ flat ☐ raised ☐ red ☐ pink ☐ purple

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

Does one body part get more hives than another? If yes, please describe:

_____

Is there any specific time that the hives are particularly difficult? If yes, describe:

_____

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

If you think that there is trigger for the hives, consider the following:

Foods: Which one(s): _____

How soon after you eat the food do the hives begin?:_____

Medications: Which one(s): _____

Any activity [exercise, hot showers, etc..] _____

Common colds? _____

Do you take any medications either prescribed, over-the-counter, herbal, GNC, homeopathic, internet, creams, lotions, eye drops, ear drops, inhalers, sprays, etc?

If yes, please list them and the approximate date that you started that medication:

Name of medication	**Approximate date started**
_____	_____
_____	_____
_____	_____

Have you recently tried any medication to treat your hives? ☐ Yes ☐ No

If yes, list the medications you've tried:

_____

Did the medication(s) help? ☐ Yes ☐ No

If yes, which one(s)? _____

Please mail completed questionnaire to:

Allergy & Immunology
One Perkins Square
Akron Ohio, 44308

Or fax to: 330-543-5207

Print form