

4. Do the hives leave marks on the skin after they are gone? _____
5. Circle the symptoms if you have experienced any of the following with the hives: swelling, difficulty breathing, difficulty swallowing, difficulty talking, difficulty walking, difficulty moving hands.
6. Do the hives become worse with heat/exercise/cold temperature/water/pressure/food (circle).
7. What type of soap/detergent/fabric softener do you use? _____
8. Do you take any vitamins _____, aspirin or aspirin-like products _____, diet drinks/artificial sweetener _____.
9. Any family history of hives or swelling? _____

10. List all medications (including prescription and over-the-counter medications) that you are currently taking:

_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____

11. List current and past medical conditions:

_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____
_____	Date started _____

12. Drug allergy or reaction to medication:

13. Home environment:

Type of heating: _____
Bed mattress, conventional or water: _____ Age _____
Pillow: feather, synthetic, other _____ Age _____
Carpeting in bedroom: _____ Yes _____ Age _____ No _____
Pets (list) _____
Do you smoke? _____ Yes _____ No _____ How much? _____ How long? _____
Does anyone else in your home smoke? _____
Do you drink alcohol? _____ Yes _____ No _____ How much? _____ How long? _____
Have there been any recent changes in your home environment? _____

14. What type of work do you do? _____

15. Is there a history of allergy in your family? (list) _____

16. Have you ever had any of the following?

Frequent headaches _____	Heartburn/acid reflux _____
Ear infection _____	Kidney trouble _____
Glaucoma _____	Liver trouble _____
Heart trouble _____	Tuberculosis _____
Thyroid problem _____	Seizures _____
Joint problems _____	Diabetes _____
Cancer _____	

17. Have you had any viral illness or respiratory tract infection preceding or during the onset of the hives/swelling? _____

18. Any recent immunizations? _____

19. Has any treatment made the hives better? _____

20. Has any treatment, activity, etc., made the hives worse? _____