Allergy & Asthma Center, P.C.

330 S. Garden Way #150
Eugene, OR 97401
541-485-0316
Fax 541-431-0317

Candice M. Rohr, M.D.
Alice H. Chou, M.D.

HIVES (URTICARIA)/ ANGIOEDEMA/ RASH

Patient Name			
Date of Birth		**Date**	

1. Date of onset of symptoms_____

Frequency of episodes:

		Dates	Duration
Intermittent	or	_____	_____
		_____	_____
		_____	_____

2. Are episodes similar yes/no? If episodes are different, please describe how they vary

_____
_____

3. Describe the appearance of skin lesions.

Symptom	**Onset**	**Location**	**Duration Continuous/Intermittent**
Hives			
Swelling			
Redness			
Itching			
Oozing/crusting			
Dryness			
Pain			

Patient's Name_____ **Birthdate**____/____/____

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. 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?_____

11. What type of work do you do?_____

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

13. Have you ever had any of the following?

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

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

15. Any recent immunizations? _____

16. Has any treatment made the hives better? _____

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