ASTHMA & ALLERGY CENTER
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Urticaria Questionnaire

Patient Name:_____ Date of Birth: _____ Date: _____

Questions (Please √ answer)	Yes	No	Questions (Please √ answer)	Yes	No
1. Have symptoms been present for > 6 weeks?	(_)	(_)	13. Is the patient taking any prescription or non-prescription medications? If yes, list:	(_)	(_)
2. Is swelling (angioedema) ever present?	(_)	(_)	14. Is the patient taking any herbal or vitamin supplements? If yes, list:	(_)	(_)
3. Do the wheals appear at a specific time of the day? If yes, when?	(_)	(_)	15. Has the patient noticed any association between the urticaria and ingestion of certain foods? If yes, list any foods?	(_)	(_)
4. Do the wheals last > 24 hours? If yes,how long? If no, describe pattern of appearance:	(_)	(_)	16. Has the patient noticed any association between the urticaria and exposure to cold, heat, sunlight, or other external factors? If yes, describe:	(_)	(_)
5. Are the wheals pruritic? If yes, is the pruritus: mild moderate severe	(_)	(_)	17. Has the patient noticed any association between the urticaria and exercise? If yes, describe:	(_)	(_)
6. Are the wheals painful?	(_)	(_)	18. Is the patient exposed to any chemicals or toxins at work? If yes, describe:	(_)	(_)
7. Do the wheals show any sign of petechial hemorrhage or bruising?	(_)	(_)	19. Is the patient exposed to any chemicals or toxins during hobbies? If yes, describe:	(_)	(_)
8. Does the patient have any other symptoms associated with the urticaria, such as dyspnea, hoarseness, or swelling of the tongue or throat? If yes, describe:	(_)	(_)	20. Has the patient taken any prescription or non-prescription medications for the urticaria? If yes, list medications and responses:	(_)	(_)
9. Does the patient have a history of atopy, such as asthma, atopic dermatitis, or allergic rhinitis? If yes, describe:	(_)	(_)	21. Does the patient have any known systemic disorders? If yes, list:	(_)	(_)
10. Is there a family history of atopy or urticaria? If yes, describe:	(_)	(_)	22. Has the patient had any recent infections? If yes, describe:	(_)	(_)
11. Has the patient traveled outside the country recently? If yes, where?	(_)	(_)	23. Is the patient's quality of life affected by the urticaria? If yes, describe:	(_)	(_)
12. Does the patient have a history of reaction to insect bites? If yes, describe:	(_)	(_)	24. Describe the current appearance and distribution of the lesions:	(_)	(_)