CHRONIC URTICARIA SCREENING

Name______________________________________________________
Age____________Date____________

I. General Features
   A. Allergic History: Personal__________________________Family__________________________
   B. Date of Onset__________________________Previous history of hives__________________________
   C. Frequency of episodes (daily, weekly)________________________________________________________
   D. Angioedema (facial, mouth swelling)_________________________________________________________
   E. Duration of each episode_______________________________________________________________
   F. Duration of individual hive_______________________________________________________________
   G. Parts of body usually affected____________________________________________________________
   H. Time of day symptoms most severe________________________________________________________
   I. Seasonal variation________________________________________________________
   J. Cyclical (?menses, pregnancy)____________________________________________________________

Other pertinent history:___________________________________________________________________________________
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II. Past Allergic History
A. Hayfever
B. Asthma
C. Previous hives

III. Drug History
A. All medications taken in past 2 months, including all prescriptions, injections, topicals, herbals & over the counter:

B. Previous history of rash after taking any drug:

III. Treatment to date:
A. Antihistamines (Benadryl, Atarax, Periactin, Claritin, Zyrtec, Allegra...)
B. H2 Blockers (Tagamet, Zantac)
C. Tricyclics (amitryptiline-Elavil, Doxepin, Pamelor...)
D. Steroids (oral or injected) (Prednisone, Medrol DosPak)
E. Epinephrine
F. Leukotriene modifiers (Singulair, Accolate...)

Symptoms when medication discontinued

IV. Foods
A. Suspected
B. Lo-cal sugar use (Equal, Sweet & Low....)
C. Scombroid fish, tuna, swordfish, red wine, aged cheese
D. Elimination diet(s) for what food(s):

V. Occupational-Recreational
Occupation Doing what
Contactants/exposures
A. Difference in symptoms between work and home
B. Change in symptoms on vacation (place?)
C. Location of occurrence: Indoors(where)_____________________________Outdoors__________________
D. Hobbies__________________________________________
E. Latex exposure_________________________________________________________________________

VI. Physical Urticaria (do any of the following cause or worsen your symptoms?)
[ ] Rubbing or scratching______________________________________________________________
[ ] Cold exposure_______________________________________________________________
[ ] Heat exposure_______________________________________________________________
[ ] Exertion_______________________________________________________________
[ ] Pressure (belt, bra...)________________________________________________________
[ ] Sun exposure_______________________________________________________________
[ ] Bathing or showering__________________________________________________________
[ ] Drying off after bathing______________________________________________________
[ ] Pet exposure_______________________________________________________________
[ ] Contact exposure (fabric softeners, detergents, soaps, shampoos, hair dyes, cosmetics...)______________________________________________________________

VII. History of Infections: check what applies and write frequency of infections
[ ] Sore throat/Strep throat____________________________________________________________________
[ ] Upper Respiratory Infections______________________________________________________
[ ] Mononucleosis________________________________________________________________________
[ ] Hepatitis/Jaundice_____________________________________________________________________
[ ] Impetigo____________________________________________________________________________
[ ] Herpes______________________________________________________________________________
[ ] Urinary Tract Infections________________________________________________________________
[ ] Fungal or Yeast Infections________________________________________________________________
[ ] Other_____________________________________________________________________________

VIII. Family History
Please specify any family members with hives or swelling.

A. ALLERGY HISTORY and REVIEW OF SYSTEMS: Do you regularly experience the following?
CONSTITUTIONAL SYMPTOMS [ ]fever[ ]chills[ ]sweats[ ]weight loss
CNS: [ ]headache[ ]dizziness [ ]fainting[ ]paralysis[ ]seizures
EYES:[ ] Red or swollen eyelids[ ] Itching[ ] Redness[ ] Tearing[ ] Sensitive to light[ ] Burning
      [ ] Discharge[ ] Dark circles under eyes [ ] Double Vision [ ]Loss of vision
EARS:[ ] Frequent Infections[ ] Itching[ ] Drainage[ ] Fullness[ ] Popping[ ] Changes in hearing[ ] pain
NOSE[ ] Itching[ ] Sneezing[ ] Discharge (clear, yellow, green )[ ] Stiffness[ ] Bleeding
[ ] Headache (location)____________________[ ] Can not smell[ ] Mouth breathing[ ] Constant nose rubbing

THROAT:[ ] Post-nasal drip[ ] Soreness[ ] Itchy throat[ ] Mucus in a.m[ ] Hoarseness[ ] No taste
[ ] Tonsils removed[ ] Adenoids removed

CHEST: [ ] Cough[ ] Night-time cough[ ] Wheezing[ ] Pain[ ] Phlegm (amount____________color_______)
[ ] Shortness of breath (at rest____with exertion____)[ ] Palpitations

ABDOMEN:[ ] Heartburn[ ] Acid regurgitation[ ] Milk intolerance[ ] Nausea[ ] Vomiting
[ ] Changes in bowel movements[ ] Diarrhea

URINARY: [ ] Pain or burning[ ] Frequency[ ] Bleeding[ ] Infections[ ] Night time urination[ ] Stones

ENDOCRINE: [ ] Diabetes[ ] Thyroid Disease[ ] Lipid disease[ ] Gout

HEMO/LYMPH: [ ] Swollen glands[ ] Anemia[ ] Easy bruising

CANCER: [ ] Type____________[ ] When____________[ ] Treatment__________________________

INFECTIOUS: [ ] Serious infections

MUSCULOSKELETAL:[ ] Pain[ ] Joint swelling[ ] Loss of mobility

SKIN:[ ] Itchy patches[ ] Dry skin[ ] Eczema (scaly crusts)[ ] Hives[ ] Swelling

PSYCHIATRIC: [ ] Depression[ ] Anxiety[ ] Other:________________________

FAMILY HISTORY OF ALLERGIES:
MOTHER______________________________________________FATHER________________________________
SISTER(s)________________________________________BROTHER(s)________________________________
CHILDREN:________________________________________

SOCIAL HISTORY:
MARITAL STATUS:_________________YEARS OF EDUCATION:_________________
ALCOHOL CONSUMPTION::
SMOKING: CURRENT:_________________PAST:_________________

PHYSICAL EXAM: P BP RESP TEMP HT WGT

GENERAL APPEARANCE
EYES: CONJUNCTIVAE SCLERAES LIDS:
NOSE: MUCOSA: SEPTUM: TURBINATES:
OROPHARYNX: TONGUE TONSILS
TEETH & GUMS: PN DRIP
EARS: TM’S: CANALS:
NECK: THYROID (ENL/Tend/MASS)
LYMPHATICS: NECK AXILLA GROIN
CVS/HEART: RHYTHM PMI HEART SOUNDS
PULSES
CHEST: PERCUSSION AUSCULTATION RALES
RHONCHI WHEEZING
ABDOMEN: SHAPE TENDERNESS MASSES
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**FOLLOW-UP:**