

# Questionnaire for patients with chronic urticaria (hives, wheals) and/or angioedema (deeply located swelling of the skin)

Name: ..... male  / female

Birth date: ..... - ..... - ..... date: ..... - ..... - .....

Please answer the following questions by marking the best answer, or (were appropriate) by writing down your answers or comments:

1. How long have you had hives and/or deep swellings?  
 I have it since .....  
 I have hives only  
 I have deep swellings only  
 I have both hives and deep swellings
  
2. How frequently do you have a bout of hives and/or deep swellings?  
 continuously  
 daily  
.... times a week  
.... times a month  
different, namely .....
  
3. How many hours does an individual hive or swelling persist before it disappears? ..... hours  
(You can determine this by marking an individual hive with a ballpoint pen when it first appears and noting the time elapsed when the hive is gone)
  
4. Have you ever had a hive or swelling which lasted more than 24 hours? Yes  / No
  
5. What is the average size of your hives? ..... centimeters
  
6. Where are your hives or swellings located?  
 I have hives:  
 all over my body  
 mostly on my arms and/or legs  
 on pressure sites (for example under the belt or the bra)  
 on the following parts of my body: .....  
  
 I have swellings:  
 of my eyelids  
 of my lips  
 of my hands and/or fingers  
 of my feet  
 of my tongue and/or throat  
 other body parts, namely .....
  
7. Do your hives leave blue, purple, brownish spots or red dots after disappearing? Yes  / No
  
8. Do you experience itchiness where you have the hives and/or swellings? Yes  / No
  
9. Do you scratch? Yes  / No
  
10. Is your skin dry and scaly where you have the hives or swellings? Yes  / No
  
11. Do you feel any other sensation(s) besides itch in the affected skin? Yes  / No   
If yes, specify:  
 pain  
 burning sensation  
 tense sensation  
 another sensation, namely .....

12. Have you experienced any of the following symptoms during or shortly after a bout of hives or swellings?  
(If yes, specify) Yes  / No

- |   |  |
|---|--|
| <input type="checkbox"/> runny nose / tearing eyes        | <input type="checkbox"/> dizziness / fainting            |
| <input type="checkbox"/> asthma or shortness of breath    | <input type="checkbox"/> gastric pain or abdominal spasm |
| <input type="checkbox"/> hoarseness                       | <input type="checkbox"/> nausea or vomiting              |
| <input type="checkbox"/> swollen tongue, palate or throat | <input type="checkbox"/> diarrhoea                       |
| <input type="checkbox"/> headache                         | <input type="checkbox"/> fatigue                         |
| <input type="checkbox"/> fever                            |  |

13. When during the day do you have the most complaints?  
 In the morning     during the day     in the evening     during the night  
 I wake up during the night because of itchiness  
 I cannot say / it varies

14. When or where do you have more hives and/or swellings?  
 inside the house     outside the house     at work  
 at home     during the weekend     during the week  
 on vacation less complaints     on vacation more complaints     I cannot say / it varies

15. Did your symptoms start after a particular infection (e.g. after an infected tooth, sinusitis, parasitic infection, pneumonia, bladder infection, or other infections)? Yes  / No

If so, following which infection? .....

16. Did your symptoms start after any of the following events: Yes  / No   
(If yes, specify)

- |   |              |
|---|--------------|
| <input type="checkbox"/> an X-ray with radio contrast media?      | Namely ..... |
| <input type="checkbox"/> taking a particular tablet or injection? | Namely ..... |
| <input type="checkbox"/> vaccinations?                            | Namely ..... |
| <input type="checkbox"/> other events?                            | Namely ..... |

17. Does a change in season or weather affect your symptoms? Yes  / No

If so, when do your symptoms aggravate? .....

18. Have you been in a tropical area? If yes, when and where? Yes  / No

.....  
.....

Sometimes bouts of hives and/or swellings are related to particular circumstances. We describe some of them in the following questions. If you recognize one or more of the circumstances, please mark the question.

19. Did your hives start approximately 15 minutes after any of the following: Yes  / No

- rubbing or scratching of the skin
- wearing tight clothing
- leaning against something (for example a chair)

20. Did your hives or the swellings occur after prolonged pressure on your skin? Yes  / No

(This type of hives occurs 4-12 hours after the prolonged pressure).  
If this happened, what kind of activities precipitated your symptoms?

- staying or walking for a long period could result in swelling of the soles
- sitting or riding bicycle could result in swelling of the buttocks
- working with tools (like pliers or a hammer)
- carrying heavy things
- other circumstances, namely .....

21. Did the hives occur after exposure to: Yes  / No

- cold weather (snow, cold wind or rain)
- cold water (shower, swimming pool, lake)
- cold objects or food (eating ice-cream or cold drinks with ice cubes)

- a change in the outside temperature
22. Have you experienced hives after any of the following: Yes  / No
- exposure to hot or warm weather  after physical exercise or during sports
- after sexual intercourse  after taking a hot shower or bath
- after consuming spicy or hot foods or drinks  after contact of your skin with warm objects
- if you are excited, frightened or under stress  if you are perspiring
23. Did you ever experience hives or swellings after exposure to sunlight? Yes  / No
24. Did you ever experience white, blue, painful or numb fingers after exposure to cold? Yes  / No
- If so, please describe the circumstance .....
25. Do you think that your hives worsen: Yes  / No
- with stress or nervousness  if you have problems of any kind.
26. Did you ever notice that contact of your skin with any of the following materials caused itching, redness or swelling of the skin? Yes  / No
- I have hives after contact of the skin with:
- wool or other clothes  animals or plants
- cosmetics or perfume  drugs
- particular food (e.g. meat, fish, vegetables, fruit), namely .....
- chemicals or other products, namely .....
27. Has any member of your family ever had hives or swellings? Yes  / No
- If yes, who? .....
28. Did you ever had one of the following diseases? Yes  / No
- hay fever, attacks of sneezing (allergic rhinitis)?
- allergic conjunctivitis?
- allergic asthma?
- childhood eczema?
- eczema in arm pits or the back of the knees (atopic dermatitis)?
29. Has any member of your family ever had one of the following diseases? Yes  / No
- hay fever, attacks of sneezing (allergic rhinitis)?
- allergic conjunctivitis?
- allergic asthma?
- childhood eczema?
- eczema in arm pits or the back of the knees (atopic dermatitis)? If yes, who?.....
30. Are you allergic to any known environmental or contact allergens like house dust mite, pollen, animals, wasp- or bee venom, rubber (eg. in latex gloves or condoms), etc.? Yes  / No
- If yes, to what? .....
- Has this been confirmed by allergy testing? Yes  / No
- Where and when? .....
31. Did you ever observe that your symptoms are related to or become worse after consuming certain foods (e.g. fish, mussels, crustaceans, celery, strawberries, pears, banana, peanuts, nuts, soy, cheese, alcohol, chocolate, juices with quinine, eggs, milk products, ice-cream, conserved food or deep frozen food products, artificial sweetener, others). Yes  / No
- If yes, after which foods? .....
32. Did you ever experience one of the following complaints after eating certain foods? Yes  / No
- tingling or a burning sensation of the tongue
- swelling of the tongue or the lips
- cramps of the intestine or diarrhoea.
33. Do you have an aversion to certain foods? Yes  / No
- If yes, against which ones? .....

34. Are you allergic to certain foods? If yes, which ones? Yes  / No
- .....
35. Did you ever follow a diet to diminish your symptoms? Yes  / No   
 Was the diet effective? Yes  / No   
 Did you have professional help from a dietitian Yes  / No   
 Did you constantly follow the diet? Yes  / No
36. Do you have animals at home? Yes  / No   
 If so, what kind of animals and since when? .....
37. Do you have a lot of contact with any of the following objects or materials?  
 plants, flowers  
 cosmetics  
 cleaning or washing products  
 paints or glues  
 other products, namely .....
38. What is your job/profession? .....
39. What kind of hobbies do you have? .....
40. Are you exposed to any airborne chemicals or industrial products in your profession Yes  / No   
 (e.g. fluids, steam, vapours or dust)?  
 If so, what kind of product? .....
41. Do you have any metallic objects (eg. pacemaker, artificial joints, metallic screws, dental implants) or other types of implants in your body? Yes  / No   
 If so, which ones?.....
42. Women only: Do you take contraceptives (eg. birth control pill) or other hormones? Yes  / No   
 If yes, which type of contraceptive and since when?  
 .....
43. Do you have more symptoms during certain times of your menstrual cycle? Yes  / No
44. Please list the drugs you used to treat your hives or angioedema in the past year:
- | name of the drug: | strength/dose: | in which period: |
|-------------------|----------------|------------------|
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
45. If you used antihistamines to prevent hives or angioedema , please indicate when you last used them?  
 .....  
 .....

46. Please name all the medication (prescription and non-prescription) and vaccinations you have used in the last year. (You can also ask your pharmacy to provide a list of the medications you used in the last year.)

Please mention antibiotics, pain medication (like aspirin), medication against the flue, anti-rheumatic drugs, sleeping pills, sedatives, psycho-pharmacologic drugs, drugs related to epilepsy, laxatives, cough medications, hormones (like oral contraceptives, estrogen, insulin), vitamins, homeopathic drugs or other drugs? If yes, which ones, when and how frequently?

name of the drug:	strength/dose:	in which period:
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

47. Are you allergic to certain drugs? Yes  / No   
If so, which one(s) and what kind of allergic reaction(s) you have had?

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48. Have you ever been hospitalized, or under the care of a medical specialist? Yes  / No   
If so, for what kind of complaints?

.....

49. Do you have any other physical complaint at the moment? Yes  / No

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50. Do you have any ideas or suggestions about the possible cause of your hives or angioedema, or have you found any relationship between certain circumstances or certain surroundings and your symptoms? Yes  / No

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### Questionnaire related to your general health

In the last 8 weeks, before the development of your hives, or at this moment have you had any of the following complaints?

- a. Do you feel tired or weak? Yes  / No
- b. Do you experience fever at this moment or recently? Yes  / No
- c. Do you lose weight? Yes  / No
- d. Do you currently have a cough? Yes  / No
- Do you have palpitations or pain in the heart region? Yes  / No
- Do you have shortness of breath during exercise? Yes  / No
- Do you have swollen ankles in the evening? Yes  / No
- e. Do you frequently feel nauseated or vomit? Yes  / No
- Do you have any gastric or stomach pains? Yes  / No
- Do you have diarrhoea or constipation? Yes  / No
- Did you ever have blood in your stools? Yes  / No
- f. Do you often have headaches? Yes  / No
- Do you often have pain in your teeth, mouth, or throat? Yes  / No
- Do you often have a cold, a stuffed nose or sinusitis? Yes  / No
- Do you frequently have pain in your ears? Yes  / No
- g. Do you frequently have muscle pains? Yes  / No
- h. Do you frequently have joint pains? Yes  / No
- i. Have you ever had a kidney disease, or bladder infection? Yes  / No
- j. Have you ever had a disease of your thyroid gland? Yes  / No
- k. Do you have diabetes? Yes  / No
- l. Did you ever receive a blood transfusion? Yes  / No
- m. Did you ever experience jaundice or liver disease (e.g. hepatitis)? Yes  / No
- n. Did you ever have Pfeiffer (infectious mononucleosis)? Yes  / No
- o. Did you have rheumatoid arthritis or lupus erythematoses (SLE)? Yes  / No
- p. Have you had any sexual transmitted diseases? Yes  / No
- q. Have you ever had any malignant diseases? Yes  / No
- If yes, which one(s)?

.....

- r. Are you smoking? If so, how many cigarettes a day? Yes  / No

.....

- s. Are you consuming alcohol? If so, how many glasses a day? Yes  / No

.....

- t. Are you using drugs? If so, which ones? Yes  / No

.....

- u. Only for women: Do you have vaginal discharge? Yes  / No
- v. Only for men: Do you have complaints related to your prostate? Yes  / No
- w. Do you regularly visit your dentist? How often in a year? Yes  / No
- x. Do you have other diseases not mentioned above? Yes  / No
- If so, which ones?

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Thank you very much for your cooperation in answering the questionnaire.

