

# 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 tong 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 "
  
- Is your skin dry and scaly where you have the hives or swellings? Yes " / No "
  
10. Do you feel any other sensation(s) besides itch in the affected skin? Yes " / No "  
If yes, specify:
  - " pain
  - " burning sensation
  - " tense sensation
  - " an other sensation, namely .....

11. Have you experienced any of the following symptoms during or shortly after a bout of hives or swellings?  
(If yes, specify) Yes " / No "
- |                                    |                                   |
|------------------------------------|-----------------------------------|
| " runny nose / tearing eyes        | " dizziness / fainting            |
| " asthma or shortness of breath    | " gastric pain or abdominal spasm |
| " hoarseness                       | " nausea or vomiting              |
| " swollen tongue, palate or throat | " diarrhea                        |
| " headache                         | " fatigue                         |
| " fever                            |                                   |
12. 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 can not say / it varies.
13. 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 can not say / it varies
14. 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? .....
15. Did your symptoms start after any of the following events: Yes " / No "  
(If yes, specify)
- " an X-ray with radio contrast media?
  - " taking a particular tablet or injection? Namely .....
  - " vaccinations? Namely .....
  - " other events? Namely .....
16. Does a change in season or weather affect your symptoms? Yes " / No "  
If so, when do your symptoms aggravate? .....
17. Have you been in a tropical area? Yes " / No "  
If yes, when and where?  
.....  
.....

*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.*

18. 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).
19. 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 .....

20. 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.
21. 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.
22. Did you ever experience hives or swellings after exposure to sunlight? Yes " / No "
23. Did you ever experience white, blue, painful or numb fingers after exposure to cold? Yes " / No "  
 If so, please describe the circumstance .....
24. Do you think that your hives worsen: Yes " / No "  
 " with stress or nervousness  
 " if you have problems of any kind.
25. Did you ever notice that contact of your skin with any of the following materials Yes " / No "  
 caused itching, redness or swelling of the skin?  
 I have hives after contact of the skin with:  
 " wool or other clothes  
 " animals or plants  
 " cosmetics or perfume  
 " drugs or particular food (e.g. meat, fish, vegetables, fruit), namely .....  
 " chemicals or other products, namely .....
26. Has any member of your family ever had hives or swellings? Yes " / No "  
 If yes, who? .....
27. Has any member of your family or have 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)?  
 If yes, who? .....
28. Are you allergic to any known environmental or contact allergens like house dust mite, Yes " / No "  
 pollen, animals, wasp- or bee venom, rubber (eg. in latex gloves or condoms), etc.?  
 If yes, to what? .....  
 Has this been confirmed by allergy testing? Yes " / No "  
 Where and when? .....
29. Did you ever observe that your symptoms are related to or become worse after consuming certain foods Yes " / No "  
 (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).  
 If yes, after which foods? .....

30. 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 diarrhea.
30. Do you have an *aversion* to certain foods? Yes " / No "  
 If yes, against which ones? .....
31. Are you *allergic* to certain foods? Yes " / No "  
 If yes, which ones? .....
32. 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 "
33. Do you have animals at home? Yes " / No "  
 If so, what kind of animals and since when? .....
34. 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 .....
35. What is your job/profession? .....
36. What kind of hobbies do you have? .....
37. Are you exposed to any airborne chemicals or industrial products in your profession (e.g. fluids, steam, vapours or dust)? Yes " / No "  
 If so, what kind of product? .....
38. 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?.....
39. *Women only*: Do you take contraceptives (eg. birth control pill) or other hormones? Yes " / No "  
 If yes, which type of contraceptive and since when?  
 .....  
 Do you have more symptoms during certain times of your menstrual cycle? Yes " / No "
40. 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: |
|-------------------|----------------|------------------|
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
| .....             | .....          | .....            |
41. If you used antihistamines to prevent hives or angioedema , please indicate when you last used them?  
 .....

42. 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:
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

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

.....

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

.....

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

.....

46. 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 "

.....  
 .....  
 .....

## 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 diarrhea 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 a 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 <i>women</i> : Do you have vaginal discharge?                 | Yes | " | / | No | " |
| v.    | Only for <i>men</i> : 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?   |     |   |   |    |   |
| ..... |  |     |   |   |    |   |

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