Hives and swelling questionnaire

For hives (urticaria) or swelling of the lips, eyes or face.

Please type your answers into this form (or print and fill it in), save it, and email it to **referrals@vidamedical.com.au** at least **7 days before your appointment**. Skip anything that doesn't apply. If you are completing this for a child, answer for the child.

About you

Full name

Date of birth

Today's date

Phone and email

Completed by (if not the patient)

Usual GP and clinic

Your hives

When did the hives start?

How often do they happen?

- ☐ Once only
- ☐ Every few weeks
- ☐ Most days
- ☐ Every day
- ☐ Come and go in episodes

What are they like?

- ☐ Each spot lasts less than 24 hours
- ☐ Spots last more than 24 hours
- ☐ Leave bruising or marks
- ☐ Burning or painful
- ☐ Swelling of lips, eyes or face
- ☐ Swelling of tongue or throat

What seems to trigger them?

- ☐ A particular food
- ☐ A medicine (e.g. ibuprofen)
- ☐ Infection or illness
- ☐ Scratching or pressure
- ☐ Heat, sweating or exercise
- ☐ Cold
- ☐ Water or sun
- ☐ Stress
- ☐ Nothing obvious

7-day hives diary

If you have hives now, fill this in once a day for the 7 days before your appointment. It uses the scoring of the Urticaria Activity Score (UAS7). Key: Hives 0 none, 1 fewer than 20, 2 between 20 and 50, 3 more than 50 or large joined areas. Itch 0 none, 1 mild, 2 moderate (troublesome), 3 intense (stops sleep or daily life).

Day	Date	Hives (0-3)	Itch (0-3)	Swelling? (Y/N)
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				
Total				

Impact

How much do hives affect your sleep?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

How much do hives affect work, study or daily life?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

Other health

- ☐ Thyroid problems
- ☐ Recent infection
- ☐ Hay fever
- ☐ Asthma
- ☐ Eczema
- ☐ Pregnant or breastfeeding

Photos help. Take a picture whenever hives or swelling appear and bring them with you.

Medicines

All medicines you take, including sprays, creams, vitamins and supplements

Do you take any of these?

- ☐ Antihistamines (e.g. Telfast, Zyrtec, Claratyne)
- ☐ Blood pressure or heart medicines
- ☐ Regular ibuprofen or aspirin
- ☐ Adrenaline autoinjector (EpiPen / Anapen)

Autoinjector expiry date (if you have one)

Family history

Does a parent, brother or sister have:

- ☐ Food allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay fever
- ☐ Hives
- ☐ Not sure

Your goals

What would you most like to get out of this appointment?

Previous allergy tests (type, date, result). Please bring copies if available.

Before you arrive

Medicines: antihistamines and some other medicines can affect allergy testing. We'll email you instructions on which to pause and when. **Keep taking your asthma medicines.**

Bring: previous test results, photos of any reactions, and your adrenaline autoinjector if you have one.

Your information is confidential and stored in your medical record in line with our privacy policy.