INTERNAL USE ONLY
Patient Name ______________________
Chart/Account # ____________ DOB __________
Doctor ______________________
Date ______________________

HIVES/ITCHING

How Long Have You Had Hives/Itching? ______________________

How often Do You Get Hive/Itching? ☐ Weekly ☐ Daily ☐ Other ______________________

How Long Does It Last Once It Comes? ______________________

Itching Present Or Not? ______________ Do You Have Any Pain Or Burning With Hives? ______________

How Does It Look To You? ______________________

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What Body Parts Are Affected? Is It All Over the Body? Head/Scalp? ______________________

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When It Goes Away, Does It Leave Any Marks Behind? ______________________

Are You Under High Stress? ______________________

Do You Take OTC Pain Killers, Like Ibuprofen, Etc.? How Often? ______________________

____

What Medications Have You Tried? Did They Help? ______________________

____

Did You See A Dermatologist? ______________________

____

Do You Have Exposure To New Contacts, Environments or Medications? ______________________

____

Do You Have Other Symptoms Like Nausea, Abdominal Pain, Fever, Weight Loss, Etc.? ______________________

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Do You Get Lip Swelling, Face Swelling, Throat Closing? How Often? ______________________

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How Often Have You Been To the ER? ______________________

What Are The Goals Of Your Visit Today? ______________________

PLEASE COMPLETE FORM PRIOR TO YOUR APPOINTMENT

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