Dakota Allergy & Asthma

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? _____

_____

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

_____

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.? _____

_____

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

_____

How Often Have You Been To the ER? _____

What Are The Goals Of Your Visit Today? _____

PLEASE COMPLETE FORM PRIOR TO YOUR APPOINTMENT

605-336-6385 Fax 605-336-6513

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