”Investigating allergic diseases in patients with hereditary angioedema due to C1-inhibitor deficiency” questionnaire

Do you have any allergic diseases?.....yes/no

If yes, what kind of allergic disease do you have?

urticaria / eczema / pollen sensitivity / food allergy/ drug allergy / pet allergy /

/ contact allergy / insect sting allergy / other: _____

If yes, for how many years have you had your symptoms? _____

Questions regarding allergic symptoms:

To make our survey more precise, we ask detailed questions about the potential allergic diseases:

Have you experienced allergic reactions on your skin? .....yes / no

If yes, what symptoms did you experience?

urticaria / eczema / itching / redness / swelling / other: _____

If yes, in what localisation?

face, head / neck / trunk / bends / extremities

Have you experienced allergic reactions in your airways? .....yes / no

If yes, what symptoms did you experience?

coughing / dyspnoea / whistling / asphyxia / other: _____

Have you experienced allergic rhinitis? .....yes / no

If yes, what symptoms did you experience?

nasal congestion / runny nose / itching nose / sneezing / other: _____

Have you experienced allergic symptoms in your eyes?.....yes / no

If yes, what symptoms did you experience?

itching / discharge / tearing up / redness / edema of the eye / other: _____

Have you experienced allergic symptoms in your intestines?.....yes / no

If yes, what symptoms did you experience?

bloating / diarrhoea / abdominal pain / other: _____

Have you experienced other allergic symptoms?.....yes / no

If yes, what symptoms did you experience?

itchy throat / loss of hearing / other: _____

Questions regarding occurrence of allergic symptoms:

How serious are your symptoms throughout the year? Please indicate in the table below, where:

0: no symptoms; 1: very mild symptoms; 2: mild symptoms; 3: average symptoms; 4: strong symptoms; 5: very strong symptoms

January	0	1	2	3	4	5	Cannot determine
February	0	1	2	3	4	5	Cannot determine
March	0	1	2	3	4	5	Cannot determine
April	0	1	2	3	4	5	Cannot determine
May	0	1	2	3	4	5	Cannot determine
June	0	1	2	3	4	5	Cannot determine
July	0	1	2	3	4	5	Cannot determine
August	0	1	2	3	4	5	Cannot determine
September	0	1	2	3	4	5	Cannot determine
October	0	1	2	3	4	5	Cannot determine
November	0	1	2	3	4	5	Cannot determine
December	0	1	2	3	4	5	Cannot determine

When do your allergic symptoms occur during the day?

in the morning / during the day / in the evening / at night-time / all day long /

/ Cannot determine

Do your allergic symptoms occur regularly during the day?

regularly / irregularly / Cannot decide / Cannot determine

In what environment do your allergic symptoms present themselves?

outdoors / in smog / after physical strain / at home / at work: _____

/ other place: _____/ Cannot determine

Have you experienced pollen sensitivity? .....yes / no

If yes, do you feel that your allergic symptoms are more frequent between March and October? ..... Much more frequent / more frequent / no

Have you experienced allergic symptoms after meals?.....yes / no

If yes, after consuming what types of food?

tomato / orange / strawberry / walnut / nuts / brown onion / garlic / mushroom /

/ other: _____

If yes, what symptoms did you experience? _____

Have you experienced allergic symptoms after taking a drug?.....yes / no

If yes, after taking what drug?_____

If yes, after taking what amount of drug? _____

If yes, what symptoms did you experience? _____

Have you experienced allergic symptoms after contact with an animal?.....yes / no

If yes, after contact with what kind of animal?

dog / cat / horse / bird / other: _____

If yes, what symptoms did you experience? _____

Have you experienced symptoms thought to be allergic after direct contact of your skin with particular materials? .....yes / no

If yes, after contact with what kind of materials?

metal (accessories, watch, buckle) / rubber gloves / cosmetics /

/ washing powder, rinsing / other:_____

If yes, what symptoms did you experience?

urticaria / eczema / itching / redness / edema / other: _____

Have you experienced allergic symptoms after being bitten by an insect?.....yes / no

If yes, after the bite of which insect?

bee / mosquito /wasp / other:_____

If yes, what symptoms did you experience? _____

Have you had skin test for allergic diseases? .....yes / no

If yes, for what reason? _____

If yes, in which year? _____

If yes, what was the result? _____

Is/was your allergy (being) treated? ..... yes / no / I am not allergic

If yes, with which drug? _____

If yes, in what form do you take it?_____

If yes, in what dosage do you take the medicine?_____

Have your allergic symptoms changed since the diagnosis of HAE?

disappeared / got better / did not change / worsened /

/ the allergy presented after the diagnosis of HAE / I am not allergic

Questions regarding HAE:

How many HAE attacks did you have between 1 October 2020 and 30 September 2021 in these regions?

abdominal: face: neck: larynx: arms: legs: genitals:

In which region are the HAE attacks the most frequent? _____

Have you experienced HAE attack after taking a drug? .....yes / no

If yes, after taking what drug?_____

If yes, after taking what amount of drug? _____

If yes, what symptoms did you experience? _____

Have you experienced HAE attack after meals? .....yes / no

If yes, after consuming what types of food?

tomato / orange / strawberry / walnut / nuts / brown onion / garlic /

/ mushroom / other: _____

If yes, what symptoms did you experience? _____

Have you experienced that your HAE attacks are more frequent between March and October?

.....yes / no

Questions regarding the connection between HAE and allergic diseases:

Does the occurrence of HAE attacks worsen your allergic symptoms?

yes / no / I am not allergic

Do HAE attacks provoke allergic symptoms?..... yes / no / I am not allergic

If yes, what kind of symptoms?_____

Do allergic symptoms provoke HAE attacks?..... yes / no / I am not allergic

If yes, what kind of symptoms?_____

General questions:

Sex ..... female / male

Age: _____ years

Place of residence .....capital / county seat / city / village

Do you have any diseases besides HAE and allergy? .....yes / no

If yes, what kind of diseases do you have? _____

Do you have asthma?.....yes / no

If yes, for how many years have you had your symptoms? _____

If yes, what medication do you take? _____

If yes, in what dosage do you take the medicine? _____

Do you regularly take some kind of medication?.....yes / no

If yes, what medicine(s) do you take? _____

If yes, in what dosage do you take the medicine? _____

Do you smoke? .....yes / no

If yes, for how many years have you been smoking? _____

If yes, how many cigarettes do you smoke daily?_____

Do you smoke e-cigarettes?.....yes / no

If yes, for how many years have you been smoking? _____

If yes, how many cigarettes do you smoke daily?_____

Did you use to smoke before? .....yes / no

If yes, for how many years did you smoke? _____

If yes, when did you quit? _____

If yes, how many cigarettes did you use to smoke daily? _____

Did you use to smoke e-cigarettes before? .....yes / no

If yes, for how many years did you smoke? _____

If yes, when did you quit? _____

If yes, how many cigarettes did you use to smoke daily? _____

How often do you consume alcohol? (Please choose the option best describing your habits)

I do not drink / 2-3 times per month / 1 time per week / 3-5 times per week / daily

How many coffees do you drink a day? _____

What is your occupation? _____

Do you have any hobbies?_____

Do you do sports regularly?.....yes / no

If yes, what kind of sport do you do? _____

How many times do you exercise a week?

1-2 / 3-4 / 5-6 / more than 6

What is the building material of the building where you live?

panel / brick / aerated concrete / mudbrick / wood / other:_____

Are there any of the following present in your home? (Please circle if yes)

wall-to-wall carpet / linoleum / wallpaper / floor heating / indoor plants / water culture /

/ moldy surface / basement / feather pillow / animal hair / pet / none of the above

Is there someone else in your family who has allergic disease? .....yes / no

If yes, who is it? _____

If yes, what kind of allergy do they have?_____

Has there been in your family? (Please circle if yes)

autoimmune disease / cancer / high blood pressure / myocardial infarction / diabetes /

/ other chronic disease: _____ / none of the above