ACCEPTED MANUSCRIPT

Physical Urticaria Questionnaire

Name ____ Type of Urticaria: (circle) Cold, Cholinergic, Solar, Dermatographism
Date of Birth __________________________________ Aquagenic, local heat, pressure, vibratory, _________
Address ______________________________________
____ Identifier_____________________________
Telephone (Home) _______________________________
(Cell)____
Email ____

1) At what age did you/your or parents first notice your condition? ________________________________

2) How would you describe your skin symptoms? (circle all that apply)

Swelling of large areas Raised welts(hives) Red Itching Burning Numb Blisters
Describe/ Other ____

3) What is your first symptom during an attack? ____

4) What conditions bring on an attack (cold air/water, wind, rubbing, exercise, swimming, eating, stress, sun exposure etc?)______________________________

5 a) Do you need to rub your skin or have wind exposure after exposure to bring out the symptoms?___
b) If yes to rubbing, how long after exposure will rubbing still give you your symptoms? ___________
c) If yes to wind exposure, how long after exposure will the wind still give you symptoms?__________
d) Will rubbing your skin without exposure give you any symptoms? ____________________________
e) Will wind exposure without exposure give you any symptoms?_______________________________

6) On what part(s) of your body do your symptoms begin?____
7) On what part(s) of your body does it spread to? ____

8) If you have rash or swelling is it limited to the area of exposure or does it involve other parts?________

9) During an attack what is the approximate temperature required to produce symptoms?________

10) What is the shortest exposure required to produce symptoms?_______________________________________

11) How long after being exposed to the conditions do your symptoms begin? Earliest_____________________
Latest______________________

12) How long after being exposed to a trigger do your symptoms last? Average ____________________________
Earliest_____________________________
Latest______________________________

13) Have you ever fainted or nearly fainted during an attack? ____
If so what were the conditions and how did you treat it? ____

14) What reaction do you have to aquatic activities such as swimming, water sports or bathing?
____

15 a) Have you ever fainted or nearly fainted from exposure to aquatic activities? __________________________
b) If so, which activities and what were the conditions? ____

16) Do you get symptoms from any of the following (circle all that apply)
Lawn mowing Carrying a bag on shoulder Drying with a towel
Ingestion of cold/hot/spicy foods or liquids Handling cold /hot objects Exercise Rubbing cold/hot skin
Exposure to a cold/hot room or cold outdoors Other____

17) Do you have or have you had any of the following symptoms associated with your episodes? (circle all that apply)
Swelling of your lips, tongue or throat Hoarseness of voice Wheezing Fever
Low Blood Pressure Fast heart rate or Palpitations Headache Confusion
Abdominal Pain Acid Stomach/Stomach Ulcers Nausea Vomiting
Diarrhea Early Delivery of a baby (if female) Joint pain Metallic taste
Painful watery eyes Sweating Excessive thirst
Other ____

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18) If you have any of the above symptoms how long after being exposed do your other symptoms last?
(specify symptom) Average_____________ Earliest____________________ Latest_________________

19) How do you treat your attacks and is it effective? (ie medications, environmental changes)?_____________
____
Have you ever needed to use epinephrine (an Epi-pen) for an attack? What were the conditions?__________
____

20) After your symptoms disappear do they reappear without a repeat exposure to the conditions that caused it? If yes specify the time delay and your symptom ____

21) How many attacks do you have Per Year?_________________ Per Month?_________________

22) How many days per year are you incapacitated by your condition?__________________________________

23 a) Was your condition worse at any particular age? If yes, what age? _______________________________
b) Better at any particular age? If yes, what age?____

24 a) Have you seen a physician for this condition?____
b) If yes, what is his/her name and telephone number? ____

25) Have you been hospitalized for this condition? ____

26 a) Have you had a cold timed skin test, exercise challenge, solar stimulation or other tests for hives in the past?____
b) If yes, what was your result?____

27 a) Have you ever had blood drawn during an attack? ____
b) If yes, where was the blood drawn?____

28) How would you rate the severity of your condition? Circle the number that applies:

0 1 2 3 4 5 6 7 8 9 10
____
mild moderate severe

29) Do you or have you had a history of of seasonal nasal allergies "hayfever", skin allergies, food allergies, eczema or drug allergies? If yes which ones____
____

30 a) What reaction, if any, have you had to insect bites?____
b)To bee stings?____
c) Did your condition worsen after these bites or stings?____

31 a) Do you have a history of blood transfusions? If yes, was it before or after your symptoms started? _____
b) If your transfusion was after your symptoms started did your symptoms worsen after it?_____________

32) Do you have a personal history of? (circle all that apply)
Tobacco use Hepatitis C Mononucleosis (EBV infection) Leukocytoclastic Vasculitis
Cryoglobinemia Lymphosarcoma Syphilis Rubeola HIV Chicken Pox Singles

33) Have you in the past or currently use any of the following (circle all that apply)?
a)Penicillin Other antibiotics____
b)Ace Inhibitors (commonly end in "pril")____
c)Angiotensin Receptor Blockers (commonly end in "sartan")_____________________________________
d)Griseofulvin ____

34) Other medical conditions____

35) Current Medications____

36) Do you have any blood related family members with a history of (circle all that apply)
Autoimmune diseases (Rheumatoid arthritis, Lupus, Vasculitis or other)
Itching/Hives Swelling of body parts Unexplained death or illness
Early infant deaths Multiple miscarriages