

Urticaria patient questionnaire

Select answers digitally, or circle them when printing. Choose all that apply unless stated.
Bring photographs of your rash and your medicine list or packets.

Name: Date of birth:

Date: Occupation:

Your rash and swelling

1 Which symptoms have you had?

☐ Raised itchy patches (hives) ☐ Deeper swelling (angioedema) ☐ Both ☐ Not sure

2 When did this problem first start?

Approximate date: Previous episode(s):

3 How long has this episode of the hives been going on? Circle one.

☐ Less than 6 weeks ☐ 6 weeks or longer ☐ Not sure

4 How often do symptoms occur? Circle one.

☐ Every day ☐ Most days ☐ Some days each week ☐ Less often ☐ Not sure

5 Do you have completely symptom-free periods?

☐ No ☐ Yes, for hours ☐ Yes, for days ☐ Yes, for weeks or months ☐ Not sure

6 How long does ONE raised patch stay in the SAME place? Circle one.

☐ Under 1 hour ☐ 1–24 hours ☐ More than 24 hours ☐ Not sure ☐ No raised patches

7 What do the raised patches feel like?

☐ Itchy ☐ Burning or stinging ☐ Painful or tender ☐ No discomfort ☐ No patches

8 What is left after a raised patch goes away?

☐ Normal skin ☐ Bruising or purple marks ☐ Dark marks ☐ Dryness or scale ☐ Not sure

9 Where do symptoms occur?

☐ Face or scalp ☐ Trunk ☐ Arms or hands ☐ Legs or feet ☐ Genitals

10 Has the problem changed since it began? Circle one.

☐ Improving ☐ About the same ☐ Worsening ☐ Comes and goes ☐ Not sure

11 When are symptoms worse?

☐ Morning ☐ Afternoon ☐ Evening or night ☐ No pattern ☐ Not sure

12 Do you have photographs showing the rash or swelling?

☐ Yes ☐ No

Episodes of deeper swelling (angioedema)

If you have never had deeper swelling, circle "No swelling" and skip questions 13–15 ☐ No swelling

13 Where have you had swelling?

☐ Eyelids ☐ Lips ☐ Tongue or inside mouth ☐ Throat ☐ Hands or feet ☐ Genitals

14 How long does ONE swelling episode last? Circle one.

☐ Less than 24 hours ☐ 1–3 days ☐ More than 3 days ☐ Not sure

15 Does swelling happen without any hives at the same time?

☐ Yes ☐ No ☐ Not sure

Episodes and possible triggers

Select answers digitally, or circle them when printing. Choose all that apply unless stated.

Symptoms during an episode

16 During rash or swelling episodes, have you had any of these?

- ☐ Trouble breathing or wheezing ☐ Changed voice ☐ Trouble swallowing
☐ Faintness or collapse ☐ Severe abdominal pain or vomiting ☐ None ☐ Not sure

17 Have you needed urgent treatment for these episodes?

- ☐ No ☐ GP urgent visit ☐ Emergency department ☐ Ambulance ☐ Hospital admission
☐ Adrenaline injection or EpiPen ☐ Breathing tube ☐ Not sure what treatment

Possible triggers

18 Circle whether symptoms start or worsen after each item. N/A = not applicable.

Do not deliberately expose yourself to something that may have caused a serious reaction.

Possible trigger	Circle one answer on each row
Rubbing, scratching or tight clothing	☐ No ☐ Yes ☐ Not sure ☐ N/A
Pressure from straps, sitting, standing or walking	☐ No ☐ Yes ☐ Not sure ☐ N/A
Cold air, cold water or cold food/drinks	☐ No ☐ Yes ☐ Not sure ☐ N/A
Heat, hot showers or baths	☐ No ☐ Yes ☐ Not sure ☐ N/A
Exercise or sweating	☐ No ☐ Yes ☐ Not sure ☐ N/A
Sunlight	☐ No ☐ Yes ☐ Not sure ☐ N/A
Water at any temperature	☐ No ☐ Yes ☐ Not sure ☐ N/A
Skin contact with products, gloves, animals or foods	☐ No ☐ Yes ☐ Not sure ☐ N/A
Work tasks, hobbies or vibration	☐ No ☐ Yes ☐ Not sure ☐ N/A
A particular food or drink	☐ No ☐ Yes ☐ Not sure ☐ N/A
Alcohol	☐ No ☐ Yes ☐ Not sure ☐ N/A
A medicine or supplement	☐ No ☐ Yes ☐ Not sure ☐ N/A
An infection or being unwell	☐ No ☐ Yes ☐ Not sure ☐ N/A
Stress or poor sleep	☐ No ☐ Yes ☐ Not sure ☐ N/A
Menstrual period (if applicable)	☐ No ☐ Yes ☐ Not sure ☐ N/A

19 If food, a medicine or a product seems involved, which one?

Name(s):

20 How soon afterwards? And does the same exposure always cause symptoms?

☐ Within 2 hours ☐ Later ☐ Not sure Always: ☐ Yes ☐ No ☐ Not sure ☐ Not applicable

Do symptoms also occur WITHOUT the exposure? ☐ Yes ☐ No ☐ Not sure ☐ Not applicable

Previous investigations

21 Which tests have you already had for this problem?

- ☐ Blood tests ☐ Skin-prick allergy tests ☐ Allergy blood tests ☐ Skin biopsy
☐ H. pylori breath or stool test ☐ Other ☐ None ☐ Not sure

Please bring any results or letters you have, including results reported as normal.

Medicines and treatments tried

Select answers digitally, or circle them when printing. Choose all that apply unless stated.

Your medicines

Bring a list or photos of ALL prescription medicines, pharmacy medicines, supplements and creams. Include medicines taken only occasionally.

22 Did you start or change any medicine near the time this began?

☐ No ☐ Yes ☐ Not sure Name if known:

23 Which of these do you take, even occasionally?

- ☐ Aspirin ☐ Ibuprofen (Nurofen) ☐ Naproxen ☐ Diclofenac (Voltaren)
☐ Codeine or other strong painkillers ☐ Antibiotics ☐ Blood pressure medicines
☐ Supplements ☐ None ☐ Not sure

24 Have you been told you have a medicine, food or insect-sting allergy?

☐ No ☐ Yes ☐ Not sure Name(s):

Has any allergic reaction caused breathing trouble or collapse, or needed adrenaline?

☐ Yes ☐ No ☐ Not sure

Treatments for the hives or swelling

25 Include antihistamines, steroid tablets and injections. Write the name and dose if you know them, or bring the packets. Use an extra medicine list if needed.

Benefit: circle 0 = none, 1 = some improvement, 2 = mostly controlled, 3 = fully controlled, or ? = unsure.

Medicine and strength	Amount taken each time	Times per day or other schedule	How long used	Taking now	Benefit
				☐ Yes ☐ No	-
				☐ Yes ☐ No	-
				☐ Yes ☐ No	-
				☐ Yes ☐ No	-
				☐ Yes ☐ No	-

26 How do you usually take your antihistamine? Circle one.

- ☐ Every day ☐ Only when symptoms occur ☐ Before a known trigger
☐ Not taking an antihistamine ☐ Not sure

27 If prescribed daily, how many days did you take it in the past 7 days?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Not prescribed daily ☐ Not sure

28 Have treatments caused problems?

- ☐ None ☐ Drowsiness ☐ Dizziness or falls ☐ Trouble concentrating
☐ Palpitations ☐ Trouble passing urine ☐ Rash or swelling got worse ☐ Not sure

Other (optional): Medicine responsible:

29 Have you stopped treatment for any of these reasons?

- ☐ No ☐ Side effects ☐ Not helpful ☐ Cost ☐ Difficult to take regularly
☐ Concern about taking it long term ☐ Symptoms improved ☐ Other ☐ Not applicable

30 Have you tried avoiding foods, changing products or another treatment?

☐ No ☐ Yes What: Helped: ☐ Yes ☐ No ☐ Not sure

Other health symptoms and impact

Select answers digitally, or circle them when printing. Choose all that apply unless stated.

Your health history

31 Have you ever had any of these conditions?

- ☐ Thyroid disease ☐ Asthma ☐ Hay fever ☐ Eczema ☐ Other autoimmune disease
☐ Kidney disease ☐ Liver disease ☐ Heart rhythm problem ☐ Epilepsy or seizures
☐ Difficulty passing urine ☐ Stomach or duodenal ulcer ☐ H. pylori infection
☐ None of these ☐ Not sure

32 Has a close blood relative had any of these?

- ☐ Hives ☐ Recurrent swelling ☐ Thyroid or autoimmune disease
☐ Asthma, hay fever or eczema ☐ None known ☐ Not sure

33 If relevant, are you pregnant, planning pregnancy or breastfeeding?

- ☐ Pregnant ☐ Planning pregnancy ☐ Breastfeeding ☐ No ☐ Not applicable

Other symptoms

34 Do you have any of these symptoms? Circle one answer on each row.

Symptom	Circle one
Repeated fevers or feeling persistently unwell	☐ Yes ☐ No ☐ Not sure
Joint pain/swelling, muscle pain or bone pain	☐ Yes ☐ No ☐ Not sure
Repeated severe abdominal pain or vomiting	☐ Yes ☐ No ☐ Not sure
Indigestion, upper abdominal pain or frequent heartburn	☐ Yes ☐ No ☐ Not sure
Ongoing diarrhoea or another change in bowel habit	☐ Yes ☐ No ☐ Not sure
Unexplained weight change	☐ Yes ☐ No ☐ Not sure
Unusual heat/cold intolerance or a racing heart	☐ Yes ☐ No ☐ Not sure
Breathing difficulty, wheeze or fainting	☐ Yes ☐ No ☐ Not sure
A recent infection, dental problem or ongoing infection symptoms	☐ Yes ☐ No ☐ Not sure

35 Recent travel or a relevant infection exposure?

- ☐ No ☐ Yes ☐ Not sure Country/exposure and when:

Impact and priorities

36 How many nights in the past 7 days was your sleep disturbed by hives or swelling?

- ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

37 What is most affected? Circle all that apply

- ☐ Sleep ☐ Work or study ☐ Exercise ☐ Relationships or social activities
☐ Appearance ☐ Mood or anxiety ☐ None

38 What would you most like help with? Circle all that apply

- ☐ Finding the cause ☐ Food or allergy concerns ☐ Swelling or breathing concerns
☐ Symptom control ☐ Medicine side effects or safety ☐ How long it will last

Other (optional):