Allergy & Sinus Center

Medical Faculty Associates

The George Washington University

Daniel Ein, M.D., FACP, FACAAI

Richard Nicklas, MD, FAAAI

Janine Van Lancker, MD

CHRONIC URTICARIA SCREENING

Name_____Age_____Date_____

I. **General Features**

A. Allergic History: Personal_____Family_____

B. Date of Onset_____Previous history of hives_____

C. Frequency of episodes (daily, weekly)_____

D. Angioedema (facial, mouth swelling)_____

E. Duration of each episode_____

F. Duration of individual hive_____

G. Parts of body usually affected_____

H. Time of day symptoms most severe_____

I. Seasonal variation_____

J. Cyclical (?menses, pregnancy)_____

Other pertinent

history:_____

___ _____

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_____

II**. Past Allergic History**

A. Hayfever_____

B. Asthma_____

C. Previous hives_____

III. **Drug History**

A. All medications taken in past 2 months, including all prescriptions, injections, topicals, herbals & over the counter:

_____

_____

_____

_____

B. Previous history of rash after taking any drug: _____

_____

III. Treatment to date:

A. Antihistamines (Benadryl, Atarax, Periactin, Claritin, Zyrtec, Allegra....) Response

_____ _____

_____ _____

_____ _____

_____ _____

H2 Blockers (Tagamet, Zantac)_____ _____

B. Tricyclics (amitryptiline-Elavil, Doxepin, Pamelor...)

_____ _____

_____ _____

C. Steroids (oral or injected) (Prednisone, Medrol DosPak)

_____ _____

D. Epinephrine_____ _____

E. Leukotriene modifiers (Singulair, Accolate...)_____ _____

Symptoms when medication discontinued_____

_____

IV. Foods

A. Suspected_____

_____

B. Lo-cal sugar use (Equal, Sweet & Low....)_____

C. Scombroid fish, tuna, swordfish, red wine, aged cheese_____

D. Elimination diet (s) for what food (s):_____

V. Occupational-Recreational

Occupation_____Doing what_____

Contactants/exposures_____

A. Difference in symptoms between work and home_____

B. Change in symptoms on vacation (place?)_____

C. Location of occurence: Indoors(where)_____Outdoors_____

D. Hobbies_____

E. Latex exposure_____

VI. Physical Urticaria (do any of the following cause or worsen your symptoms?)

[ ] Rubbing or scratching_____

[ ] Cold exposure_____

[ ] Heat exposure_____

[ ] Exertion_____

[ ] Pressure (belt, bra....)_____

[ ] Sun exposure_____

[ ] Bathing or showering_____

[ ] Drying off after bathing_____

[ ] Pet exposure_____

[ ] Contact exposure (fabric softeners, detergents, soaps, shampoos, hair dyes, cosmetics...)_____

_____

VII. History of Infections: check what applies and write frequency of infections

[ ] Sore throat/Strep throat_____

[ ] Upper Respiratory Infections_____

[ ] Mononucleosis_____

[ ] Hepatitis/Jaundice_____

[ ] Impetigo_____

[ ] Herpes_____

[ ] Urinary Tract Infections_____

[ ] Fungal or Yeast Infections_____

[ ] Other_____

VIII. Family History

Please specify any family members with hives or swelling.

A. <u>ALLERGY HISTORY and REVIEW OF SYSTEMS</u> : Do you regularly experience the following?

CONSTITUTIONAL SYMPTOMS [ ]fever[ ]chills[ ]sweats[ ]weight loss

CNS: [ ]headache[ ]dizziness [ ]fainting[ ]paralysis[ ]seizures

EYES:[ ] Red or swollen eyelids[ ] Itching[ ] Redness[ ] Tearing[ ] Sensitive to light[ ] Burning

[ ] Discharge[ ] Dark circles under eyes [ ] Double Vision [ ]Loss of vision

EARS:[ ] Frequent Infections[ ] Itching[ ] Drainage[ ] Fullness[ ] Popping[ ] Changes in hearing[ ] pain

NOSE[ ] Itching[ ] Sneezing[ ] Discharge (clear, yellow, green)[ ] Stuffiness[ ] Bleeding

[ ] Headache (location)_____[ ] Can not smell[ ] Mouth breathing[ ] Constant nose rubbing

THROAT:[ ] Post-nasal drip[ ] Soreness[ ] Itchy throat[ ] Mucus in a.m[ ] Hoarseness [ ] No taste
[ ] Tonsils removed [ ] Adenoids removed

CHEST: [ ] Cough[ ] Night-time cough [ ] Wheezing[ ] Pain[ ] Phlegm (amount_____color___ ____)
[ ] Shortness of breath (at rest____ with exertion____)[ ] Palpitations

ABDOMEN:[ ] Heartburn[ ] Acid regurgitation [ ] Milk intolerance[ ] Nausea[ ] Vomiting
[ ] Changes in bowel movements[ ] Diarrhea

URINARY: [ ] Pain or burning[ ] Frequency [ ] Bleeding[ ] Infections[ ]night time urination[ ]stones

ENDOCRINE: [ ] Diabetes [ ] Thyroid Disease[ ]lipid disease[ ]gout

HEMO/LYMPH: [ ] Swollen glands [ ] Anemia [ ] Easy bruising

CANCER: [ ] type_____ [ ]when_____ [ ]treatment_____

INFECTIOUS: [ ] serious infections

MUSCULOSKELETAL:[ ] Pain[ ] Joint swelling[ ] Loss of mobility

SKIN:[ ] Itchy patches[ ] Dry skin[ ] Eczema (scaly crusts)[ ] Hives [ ]Swelling

PSYCHIATRIC;[ ] Depression[ ] Anxiety[ ] Other:_____

FAMILY HISTORY OF ALLERGIES :

MOTHER_____FATHER_____

SISTER(s)_____BROTHER(s)_____

CHILDREN :_____

SOCIAL HISTORY:

MARITAL STATUS: YEARS OF EDUCATION:

ALCOHOL CONSUMPTION::

SMOKING: CURRENT: PAST:

PHYSICAL EXAM: P BP RESP TEMP HT WGT

GENERAL APPEARANCE

EYES: CONJUNCTIVAE SCLERAE LIDS::

NOSE: MUCOSA: SEPTUM: TURBINATES:

OROPHARYNX: TONGUE TONSILS

TEETH & GUMS: PN DRIP

EARS: TM'S: CANALS:

NECK: THYROID (ENL/Tend/MASS)

LYMPHATICS: NECK AXILLA GROIN

CVS/HEART: RHYTHM PMI HEART SOUNDS

PULSES

CHEST: PERCUSSION AUSCULTATION RALES

RHONCHI WHEEZING

ABDOMEN: SHAPE TENDERNESS MASSES

LIVER SPLEEN

SKIN: RASH LESION FLEXURAL ECZEMA:

EXTREMITIES: CYANOSIS CLUBBING EDEMA

PULSES

NEURO/PSYCH: ORIENTATION AFFECT

Diagnosis	**Plan**
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

FOLLOW-UP: