HIVE/SWELLING/ITCHING/RASH ADDENDUM FORM

NAME____ **AGE**_________ **SEX**_________ **DATE**______________

I. **GENERAL FEATURES:**

A. Date of onset of problem____

B. Frequency of attacks (i.e., daily, weekly, etc.)_________________________

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C. Duration of attacks____

D. Time of day when symptoms most severe: Mornings Afternoon Evening

Night After meals Other____

E. Where on your body does your problem occur most often?_________________

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F. How large are they?____________________How do they feel?_____________

G. Any wheezing or loss of consciousness?______________________________

H. Have you required emergency treatment for this problem?_______________

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II. **PHYSICAL:**

Do any of the following produce your symptoms?

A. Heat exposure

B. Sunlight exposure

C. Rainy or wet periods

D. Hot bath/shower

E. Pressure, prolonged sitting

F. Friction, clothing contact

G. Cold exposure(water,wind,swimming)

H. Exercise

I. Damp rooms/areas (molds)

J. Sexual intercourse

K. Vibration/rubbing/scratching

L. Insect bites or stings

III. What do <u>you</u> think causes your symptoms ? ________________________________

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