

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.) \_\_\_\_\_
- 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? \_\_\_\_\_
- 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? \_\_\_\_\_

II. PHYSICAL:

Do any of the following produce your symptoms?

- |                                |                                       |
|--------------------------------|---------------------------------------|
| A. Heat exposure               | G. Cold exposure(water,wind,swimming) |
| B. Sunlight exposure           | H. Exercise                           |
| C. Rainy or wet periods        | I. Damp rooms/areas (molds)           |
| D. Hot bath/shower             | J. Sexual intercourse                 |
| E. Pressure, prolonged sitting | K. Vibration/rubbing/scratching       |
| F. Friction, clothing contact  | L. Insect bites or stings             |

III. What do you think causes your symptoms ? \_\_\_\_\_

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