Hives/Urticaria/Angioedema
(only fill out if you are being seen for hives or swelling)

Asthma & Allergy Institute of Michigan
Jeffrey M. Bruner, D.O., P.C.
John Frith, D.O.
Amanda Thomas MS, PA-C
42607 Garfield, Clinton Twp., MI 48038
586.286.9010

Patient Name: ___________________________ Date: __________

Briefly describe your main reason for seeing us today:

When did the hives begin?

Have you had any swelling (angioedema) of the lips, eyes, tongue, or any body parts?

Where on your body do the hives occur?

How often do you have hives?

What medications have you taken to treat hives and/or angioedema?

How long does each individual hive last? (circle) <24 hours >24 hours

Do they itch? (circle) Yes No

Are they painful? (circle) Yes No

Do you experience any of the following? (circle appropriate symptoms)

shortness of breath | wheezing | chest tightness | abdominal pain | throat fullness | dizziness | diarrhea

Do you take any aspirin related medications ever? (Ibuprofen, Advil. Aspirin, Aleve, Naproxen, etc.)

(circle) Yes No

Have you recently experienced any of the following? (circle appropriate symptoms)

fever	chills	night sweats	swollen glands	swollen joints	weight gain	weight loss

What "triggers" the hives / swelling? (circle)

stress	vibration	exercise	medications	friction
home	food	pressure	work	heat
sunlight	cold	water	other	do not know

Does anyone in you family have a history of swelling disorders/angioedema? (circle) Yes No

Have you ever had hives / angioedema in the past? (circle) Yes No

If yes, when and how long did they last?

Do you or does anyone in your family have any history of thyroid disease? (circle) Yes No