

A. Do hives appear to occur in relation to any of the following?

| | | |
|---|---|---|
| Indoors only or predominantly | Y | N |
| Rooms/locations in particular | Y | N |
| _____ Workshop _____ Basement _____ Attic | | |

Other: _____

| | | |
|--------------------------------|---|---|
| Outdoors only or predominantly | Y | N |
| At work predominantly | Y | N |
| At home predominantly | Y | N |
| At another location | Y | N |

Where? _____

| | | |
|------------------------------------|---|---|
| During work week predominantly | Y | N |
| On weekends predominantly | Y | N |
| Improve while away on vacation | Y | N |
| Related to recreational activities | Y | N |

Which types? _____

| | | |
|----------------------|---|---|
| Occur with housework | Y | N |
|----------------------|---|---|

7. History of Infections

A. Have you recently had any of the following infections or symptoms of infection?

| | |
|---|--|
| _____ Sore throat/strep | _____ Fungal infection of skin, hair, or nails |
| _____ Swollen lymph glands | _____ Tooth/gum infection |
| _____ Mononucleosis | _____ Sinus infection |
| _____ Impetigo/skin infections | _____ Diarrhea or constipation |
| _____ Jaundice/hepatitis | _____ Feeling hot or cold |
| _____ Pneumonia | _____ Weight loss |
| _____ Yeast infection | _____ Fever |
| _____ Painful urination/urinary tract infection | _____ Fatigue |
| _____ Infection of gall bladder | _____ Unusual bruising |
| _____ Other: _____ | |

8. History of Allergy or Allergic Symptoms

A. Do you have any of the following types of allergy or allergic symptoms?

| | |
|----------------------------------|--|
| _____ Hay fever/sinus congestion | _____ Nausea/abdominal pains/diarrhea |
| _____ Wheezing/asthma | _____ Swelling of lips or mouth after eating |
| _____ Itching of skin | _____ Known allergic agents |
| _____ Eczema | _____ Previous skin testing for allergies |
| _____ Excessive tearing | _____ Family history of these problems |

9. Past Medical History

A. List past/present medical problems _____

B. When was your last

| | |
|-------------------|----------------------|
| Chest X-ray _____ | Breast exam _____ |
| Rectal exam _____ | Mammogram _____ |
| Pelvic exam _____ | Urine analysis _____ |