UCSF Health Allergy & Immunology Clinic

Click here to email form to: AllergyID.Nurse@ucsf.edu

Biologic Injection Form

URTICARIA CONTROL TEST

Please write in the number that most closely matches your symptoms.

1. How much have you suffered from the physical symptoms of the urticaria (itch, hives (welts) and/or swelling) in the last four weeks?

Not at all	(4)	
A little	(3)	
Somewhat	(2)	
Much	(1)	
Very much	(0)	_____

2. How much was your quality of life affected by the urticaria in the last 4 weeks?

Not at all	(4)	
A little	(3)	
Somewhat	(2)	
Much	(1)	
Very much	(0)	_____

3. How often was the treatment for your urticaria in the last 4 weeks not enough to control your urticaria symptoms?

Not at all	(4)	
Seldom	(3)	
Sometimes	(2)	
Often	(1)	
Very often	(0)	_____

4. Overall, how well have you had your urticaria under control in the last 4 weeks?

Very well	(4)	
Well	(3)	
Somewhat	(2)	
A little	(1)	
Not at all	(0)	_____

TOTAL 0

A higher score suggests that urticaria is well-controlled

If you have asthma, please fill in this section.

ASTHMA CONTROL TEST

Peak Flow:_____ [date]:_____

Please write in the number that most closely matches your symptoms.

1. In the past four weeks, how often did your asthma keep you from getting as much as you would like done at work or at home?

None of the time	(5)	
A little of the time	(4)	
Some of the time	(3)	
Most of the time	(2)	
All of the time	(1)	_____

2. During the past four weeks, how often have you had shortness of breath?

Not at all	(5)	
Once or twice a week	(4)	
3 to 6 Times a week	(3)	
Once a day	(2)	
More than once a day	(1)	_____

3. During the past four weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night, or earlier than usual in the morning?

Not at all	(5)	
Once or twice	(4)	
Once a week	(3)	
2 to 3 nights a week	(2)	
4 or more nights a week	(1)	_____

4. During the past four weeks, how often have used your rescue inhaler or nebulizer medication (such as albuterol)

Not at all	(5)	
Once a week or less	(4)	
A few times a week	(3)	
1 or 2 times per day	(2)	
3 or more times per day	(1)	_____

5. How would you rate your asthma control during the past four weeks?

Completely controlled	(5)	
Well controlled	(4)	
Somewhat controlled	(3)	
Poorly controlled	(2)	
Not controlled at all	(1)	_____

TOTAL 0