Patient Name: _____ _____ Date Range:_____

First Last

Urticaria (Hives) Activity Legend				
	Score			
	0	1	2	3
Number of Hives (H)	None	<20	20-50	>50
Itching Intensity (I)	None	Mild	Moderate	Severe

Week (DD/MM/YY) of the ***Monday***	Mon H	Mon I	Tues H	Tues I	Wed H	Wed I	Thurs H	Thurs I	Fri H	Fri I	Sat H	Sat I	Sun H	Sun I	Total
1.															
2.															
3.															
4.															

Urticaria Medications									
Drug name:	Week # (1, 2,…)	Dose	Dose	Dose	Dose	Dose	Dose	Dose	Total