

Urticaria Control Test

Patient name: _____ Date: (dd mm yyyy): ____ ____ ____

Date of birth (dd mm yyyy): ____ ____ ____

Instructions: You have urticaria. The following questions should help us understand your current health situation. Please read through each question carefully and choose an answer from the five options that *best fits* your situation. Please limit yourself to *the last four weeks*. *Please don't think about the questions for a long time*, and do remember to answer *all questions* and to provide *only one answer to each question*.

1. How much have you suffered from the **physical symptoms of the urticaria (itch, hives (welts) and/or swelling)** in the last four weeks?
 very much much somewhat a little not at all
2. How much was your **quality of life** affected by the urticaria in the last 4 weeks?
 very much much somewhat a little not at all
3. How often was the **treatment** for your urticaria in the last 4 weeks **not enough** to control your urticaria symptoms?
 very often often sometimes seldom not at all
4. **Overall**, how well have you had your urticaria **under control** in the last 4 weeks?
 not at all a little somewhat well very well