



# Central Mass Allergy and Asthma Care

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Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Please record the amount of hives present and the severity of itch you experience on a daily basis using the scoring system below

DAY

SCORE WHEALS/24H

SCORE ITCH/24H

SUM

DAY	SCORE WHEALS/24H			SCORE ITCH/24H				SUM
	None	<20	20-50	>50	Absent	Mild	Moderate	
1	0	1	2	3	0	1	2	3
2	0	1	2	3	0	1	2	3
3	0	1	2	3	0	1	2	3
4	0	1	2	3	0	1	2	3
5	0	1	2	3	0	1	2	3
6	0	1	2	3	0	1	2	3
7	0	1	2	3	0	1	2	3

DAY

SCORE WHEALS/24H

SCORE ITCH/24H

SUM

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	None	<20	20-50	>50	Absent	Mild	Moderate	
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4	0	1	2	3	0	1	2	3
5	0	1	2	3	0	1	2	3
6	0	1	2	3	0	1	2	3
7	0	1	2	3	0	1	2	3