APPENDIX 7. SCORES USED IN CHRONIC SPONTANEOUS URTICARIA : AAS, DLQI, CU-Q_2oL, Urticaria control test

AAS

(Angioedema Activity Score)

Angioedema activity documentation

Patient name: _____

Date questionnaire completed (dd mmm yyyy): ____ ____ _____

Week 1:

Instructions: Please document your symptoms retrospectively once a day. Refer to the last 24 hours in each case. Please answer all questions as fully as possible

		Day						
		1	2	3	4	5	6	7
Have you had a swelling episode in the last 24 hours?	no							
	yes							
⇩ **Please answer the questions below about this swelling episode during the last 24 hours. If you did not have a swelling episode, leave them blank.**								
At what time(s) of day was this swelling episode(s) present? (please select all applicable times)	midnight – 8 a.m.							
	8 a.m. – 4 p.m.							
	4 p.m. - midnight							
How severe is / was the physical discomfort caused by this swelling episode(s) (e.g., pain, burning, itching?)	no discomfort							
	slight discomfort							
	moderate discomfort							
	severe discomfort							
Are / were you able to perform your daily activities during this swelling episode(s)?	no restriction							
	slight restriction							
	severe restriction							
	no activities possible							
Do / did you feel your appearance is / was adversely affected by this swelling episode(s)?	no							
	slightly							
	moderately							
	severely							
How would you rate the overall severity of this swelling episode?	negligible							
	mild							
	moderate							
	severe							

DERMATOLOGY LIFE QUALITY INDEX

Hospital No: Date: **DLQI SCORE:**
Name:
Address: Diagnosis:

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK. Please tick ✓ one box for each question.

1.	Over the last week, how **itchy**, **sore**, **painful** or **stinging** has your skin been?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	
2.	Over the last week, how **embarrassed** or **self conscious** have you been because of your skin?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	
3.	Over the last week, how much has your skin interfered with you going **shopping** or looking after your **home** or **garden**?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒
4.	Over the last week, how much has your skin influenced the **clothes** you wear?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒
5.	Over the last week, how much has your skin affected any **social** or **leisure** activities?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒
6.	Over the last week, how much has your skin made it difficult for you to do any **sport**?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒
7.	Over the last week, has your skin prevented you from **working** or **studying**?	Yes No	❒ ❒	 Not relevant ❒
	If "No", over the last week how much has your skin been a problem at **work** or **studying**?	A lot A little Not at all	❒ ❒ ❒	
8.	Over the last week, how much has your skin created problems with your **partner** or any of your **close friends** or **relatives**?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒
9.	Over the last week, how much has your skin caused any **sexual difficulties**?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒
10.	Over the last week, how much of a problem has the **treatment** for your skin been, for example by making your home messy, or by taking up time?	Very much A lot A little Not at all	❒ ❒ ❒ ❒	 Not relevant ❒

Please check you have answered EVERY question. Thank you.

Chronic Urticaria Quality of Life Questionnaire (CU-Q_2oL)

In the past 14 days how much were you troubled by the following symptoms?

	Not at all	A little	Rather	A lot	Very much
1. Itching					
2. Wheals					
3. Swelling of your eyes					
4. Swelling of your lips					

Indicate how often you were limited by your hives (urticaria) in the past 14 days in the following areas of daily life

	Never	Rarely	Sometimes	Often	Very often
5. Work					
6. Physical activities					
7. Sleep					
6. Free time					
7. Sleep					
8. Free time					
9. Social relationships					
10. Eating					

In the following questions, we would like to know more about the difficulties and problems that could be related to your hives (urticaria) (regarding the past 14 days)

	Never	Rarely	Sometimes	Often	Very often
11. Do you have difficulties falling asleep ?					
12. Do you wake up at night?					
13. Are you tired during the day because you did not sleep well at night?					
14. Do you have difficulties concentrating?					
15 .Do you feel nervous?					
16. Do you feel miserable?					
17. Do you have to limit your food choices?					
18. Are you bothered by the symptoms of hives (urticaria) that appear on your body?					
19. Are you embarrassed to go to public places?					
20. Is it a problem for you to use cosmetics (e.g. perfumes, creams, lotions, bubblebath, make up)?					
21. Do you have to limit your clothing choices?					
22. Are your sports activities limited because of your hives (urticaria)?					
23. Do you suffer side-effects from the medications you take for hives (urticaria)?					

Available on www. urticaria-registry.com

Urticaria control test

Date: _____

Last Name, First Name: _____

Date of Birth: _____

Instructions : 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.*

Name

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

   O very much O much O somewhat O a little O not at all

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

   O very much O much O somewhat O a little O not at all

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

   O very often O often O sometimes O seldom O not at all

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

   O not at all O a little O somewhat O well O very well

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