GRANGER MEDICAL CLINIC

Richard W. Hendershot, MD

Adult and Pediatric
Allergy, Asthma, & Immunology

Please fill out this form prior to your visit.

Patient Name: _____ Age: _____ Date: _____
Address: _____
Would you like a summary letter sent to your primary or referring doctor? ☐ Yes ☐ No
Primary Care Provider: _____ Address: _____
Referring Provider: _____ Address: _____
Are there other family members that are seen at this clinic? ☐ Yes ☐ No

Environmental Conditions
Occupation: _____ Hobbies: _____
How long have you lived in Utah? _____
Age of home: _____ Years at present address: _____
Pets (type and quantity): ☐ Cat(s) ___ ☐Dog(s) ___ ☐Bird(s) ___ ☐ Other: _____
Are pets outdoors? ☐ Yes ☐ No
If in the house, are they in the bedroom? ☐ Yes ☐ No
Heating system: ☐ Gas ☐ Electric ☐ Wood ☐ Coal ☐ Oil
Air conditioning: ☐ Yes ☐ No If yes, type: ☐ Central ☐ Swamp ☐ Window
Air filtering system: ☐ Yes ☐ No If yes, type: ☐ Central ☐ Room
Humidifier: ☐ Yes ☐ No If yes, type: ☐ Central ☐ Room
Fireplace: ☐ Yes ☐ No ☐ Gas ☐ Electric ☐ Wood
Water damage in home? ☐ Yes ☐ No
Farm animals near home? ☐ Yes ☐ No What kind? _____
Neighborhood: ☐ City ☐ Rural ☐ Suburbs ☐ Country

Review of General Health
Check all you have experienced:
General: ☐ Chronic fever ☐ Increased fatigue ☐ Unintentional weight loss ☐ Other:_____
Eyes: ☐ Vision changes ☐ Itching
Ears, nose, and throat: ☐ Ear aches ☐ Runny nose ☐ Congestion
☐ Sore throat ☐ Itchy throat ☐ Nose bleeds
Lungs: ☐ Shortness of breath ☐ Chest tightness ☐ Cough ☐ Wheeze
Heart: ☐ Chest pain ☐ abnormal heart beat ☐ Fainting spells
Skin: ☐ New rash ☐ Itching ☐ Easy blistering
Endocrine: ☐ Hot flashes ☐ cold or heat intolerance ☐ Thirst
Blood/Lymph: ☐ Swollen glands ☐ Easy bruising ☐ Anemia
Psychiatric: ☐ Depression ☐ Anxiety
Immune system: ☐ diagnosed immune deficiency
List any other health issues: _____

Medication
Please list all current medications.

_____ _____ _____
_____ _____ _____

Family History

Check boxes below applicable family members to indicate a history:

	Mother	Father	Sibling	Child
Hay fever, or other, nasal allergy:	☐	☐	☐	☐
Asthma:	☐	☐	☐	☐
Eczema:	☐	☐	☐	☐
Hives:	☐	☐	☐	☐
Food allergy:	☐	☐	☐	☐

Family history of other diseases (list): _____

Smoking History

Do you smoke? ☐ Yes ☐ No

If yes, what? ☐ tobacco ☐ vape ☐ marijuana

Daily Amount: _____ How many years? _____ Others smoke at home: ☐ Yes ☐ No

Medical History

Check all that you experience:

☐ Heartburn ☐ Emphysema ☐ Nasal Polyps ☐ Heart Disease ☐ Ulcers

☐ Diabetes ☐ Glaucoma ☐ Cataracts ☐ Urine Retention ☐ High Blood Pressure

☐ Cancer (list type) _____

☐ Other Diseases: _____

☐ Birth Problems: _____

☐ Growth and Development Problems: _____

☐ Medication Allergies (list): _____

Hospitalization/Surgery/Emergency visits

If you have ben hospitalized, undergone surgery, or been admitted at an Emergency Department, please list the reason and date of each occurrence:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

For the following sections (1-7), please fill out only those sections that pertain to you.

1) Hay Fever, Chronic Nasal Congestion, Seasonal Allergies, or Pet Allergy

Check all symptoms that apply:

Nose	Eyes	Ears	Throat	Chest
☐ Hay Fever	☐ Itching	☐ Itching	☐ Itching	☐ Asthma
☐ Congestion	☐ Tearing	☐ Blockage	☐ Hoarseness	☐ Cough
☐ Sneezing	☐ Swelling	☐ Infections	☐ Voice Loss	☐ Wheeze
☐ Running	☐ Redness	☐ Discharge	☐ Infections	☐ Mucus
☐ Itching	☐ Styes	☐ Hearing Loss	☐ Postnasal Drip	☐ Tightness
☐ Polyps		☐ Earaches	☐ Soreness	☐ Short Breath
☐ Bleeding			☐ Bad Breath	☐ Pneumonia
☐ Loss of Smell			☐ Dryness	☐ Congestion
☐ Sinus Infections				☐ Bronchitis

Have allergy skin tests been done before? ☐ Yes ☐ No

Have allergy blood tests been done before? ☐ Yes ☐ No

Provider: _____ Date: _____

Results: _____ Allergy shots? ☐ Yes ☐ No from _____ to _____

When do these symptoms occur? ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ All year long

How long have you had these symptoms? _____ Years Worsening? ☐ Yes ☐ No

Which of the following appear to cause these symptoms? (check all that apply)

Pollen:	☐ trees	☐ grass	☐ weeds	
Animals:	☐ cats	☐ dogs	☐ horses	
	☐ other animals (list) _____			
Odors:	☐ detergents	☐ soaps	☐ hair spray	
	☐ paint fumes	☐ perfumes	☐ tobacco smoke	
Other:	☐ food	☐ excitement	☐ fatigue	☐ medications (aspirin etc.)
	☐ inversions	☐ cold air	☐ exercise	☐ infections (colds)
	☐ laughing	☐ house dust	☐ stress	☐ weather changes
	☐ nighttime	☐ other (list) _____		

What medications have you taken for your **hay fever/congestion** symptoms? Please indicate response:

Medication	**Helpful?**	**Medication**	**Helpful?**
_____	☐ yes ☐ no ☐ some	_____	☐ yes ☐ no ☐ some
_____	☐ yes ☐ no ☐ some	_____	☐ yes ☐ no ☐ some

2) Asthma/Chest Problems

How long have you had these symptoms? _____ Years Worsening? ☐ Yes ☐ No

What triggers these symptoms? _____

How often do you wake at night because of cough or wheezing? _____

How often do you use "rescue" medication (e.g. albuterol)? _____ With exercise? _____

How long ago did you last need prednisone for your asthma? _____

How long ago did you last need urgent care for your asthma? _____

Do you use a peak flow meter? ☐ Yes ☐ No Personal best? _____

Date of last chest x-ray: _____ Date of last sinus x-ray/CT scan: _____

What medications have you taken for your **asthma** symptoms? Please indicate response:

Medication	**Helpful?**	**Medication**	**Helpful?**
_____	☐ yes ☐ no ☐ some	_____	☐ yes ☐ no ☐ some
_____	☐ yes ☐ no ☐ some	_____	☐ yes ☐ no ☐ some

3) Adverse Reactions to Food

List specific foods and describe reaction:

Food: _____ Reaction: ☐ anaphylaxis ☐ hives ☐ wheezing ☐ itchy mouth ☐ throat swelling ☐ eczema ☐ vomiting

Other reaction: _____ When was first reaction? _____ Most recent? _____

Food: _____ Reaction: ☐ anaphylaxis ☐ hives ☐ wheezing ☐ itchy mouth ☐ throat swelling ☐ eczema ☐ vomiting

Other reaction: _____ When was first reaction? _____ Most recent? _____

Food: _____ Reaction: ☐ anaphylaxis ☐ hives ☐ wheezing ☐ itchy mouth ☐ throat swelling ☐ eczema ☐ vomiting

Other reaction: _____ When was first reaction? _____ Most recent? _____

What treatment(s) is/are usually needed? ☐ Benadryl ☐ Zyrtec ☐ Claritin ☐ Epi-pen ☐ steroids

Do you have an Epi-pen/Epi-pen Jr.? ☐ Yes ☐ No

4) Eczema

How old was the patient when this started? _____ Has it been: ☐ continuous ☐ intermittent

What other symptoms are there with the eczema? ☐ itching ☐ sleep problems ☐ redness ☐ infections

What treatment is used? ☐ ointments ☐ creams ☐ baths ☐ wraps

What medications are used?

topical steroids (list) _____

oral medications (list) _____

5) Insect Sting Reaction

Insect: _____ Reaction: ☐ swelling ☐ anaphylaxis ☐ hives ☐ wheezing ☐ feeling faint ☐ nausea

Insect: _____ Reaction: ☐ swelling ☐ anaphylaxis ☐ hives ☐ wheezing ☐ feeling faint ☐ nausea

Other reaction: _____

Date of first reaction: _____ Most recent reaction: _____

Treatment: ☐ Benadryl ☐ Zyrtec ☐ Claritin ☐ Epi-pen ☐ ER ☐ steroids

Do you have an Epi-pen/Epi-pen Jr.? ☐ Yes ☐ No

6) Hives/Itching/Swelling

Do you have: ☐ Hives ☐ Swelling ☐ Both

Date of onset: _____most recent episode: _____

How often do you have the hives/itch: Daily: _____ Weekly: _____ Monthly: _____

How often do you have the swelling: Daily: _____ Weekly: _____ Monthly: _____

If intermittent, how long do they last? _____ Minutes _____ Hours _____ Days _____ Weeks

Time of day when symptoms are most severe: _____

Parts of body affected by **hives/itch:** _____

Parts of body affected by **swelling:** _____

Do the hives: ☐ itch ☐ bruise ☐ worsen with scratching ☐ move daily

Do any of the following seem to be associated with the hives, itch or swelling (check all that apply)?

☐ exercise ☐ soap ☐ cosmetics ☐ detergents ☐ latex ☐ stress ☐ cough
☐ wheezing ☐ cold ☐ heat ☐ sunlight ☐ pressure ☐ vibration ☐ animals
☐ indoors ☐ outdoors ☐ nighttime ☐ pregnancy ☐ daytime ☐ at home ☐ at work
☐ menstrual periods ☐ tight clothing ☐ foods (list): _____
☐ Any other specific associations? _____

Do you have any problems with the following? (circle all that apply)

☐ sore throat ☐ pneumonia ☐ painful urination ☐ sinus infections ☐ yeast infections
☐ fever ☐ hepatitis ☐ swollen glands ☐ mononucleosis ☐ skin infections
☐ diarrhea ☐ thyroid disease ☐ tooth/gum infection
☐ any autoimmune disease (e.g. lupus, arthritis) _____

Please indicate the treatments that have been used in the past for your hives. Score your response to each type of therapy: **0: No response** **1: Slight response** **2: Moderate response** **3: Complete clearing**

Antihistamine	Response	Steroids	Response

Antibiotics	Response	Diet changes	Response

Other	Response		

7) Other Allergy Concerns and/or Symptoms

_____

_____

_____

_____

_____

_____