The Christ Hospital Physicians™
Ear, Nose & Throat

Collin Burkart, MD
Joseph Hellmann, MD
Thomas Kereiakes, MD
Ernest Manders, MD
Michael Wood, MD

New Patient Medical History

Today's Date: ____ / ____ / ____ **Date of Birth:** ____ / ____ / ____

Your Name: _____ **Age:** _____ **Occupation:** _____

Medication Allergies: NO YES (List) 1. _____ 2. _____ 3. _____ 4. _____

Current Medications: Please list your present medications: (Prescription, Over-the-counter, Vitamins and Supplements:

1) _____ 4) _____ 7) _____
2) _____ 5) _____ 8) _____
3) _____ 6) _____ 9) _____

Smoking: Never _____ Yes _____ # _____ Packs per day for _____ years. Quit in _____ (year)
Alcohol: Never _____ Yes _____ # _____ Drinks per day.

Past Medical History: Do you have or have you ever had the following?

Yes No **Diabetes**
If Yes: Do you take Insulin: Yes ____ No ____ How long have you been diabetic (Years): _____

Yes No **Asthma**
If Yes: Have you ever required steroids? _____ Do you use inhalers? _____

Yes No **Ulcers**
If Yes: Circle type: Stomach Duodernal Can you take Aspirin, Motrin, Advil or other anti-inflammatories?: Yes No

Yes No **Liver Disease**
If Yes: Circle type Hepatitis B Hepatitis C Cirrhosis Other: Is it presently active?: Yes No

Yes No **Kidney Disease**
If Yes: Problem: _____ Are you under dialysis?: Yes No Have you had a transplant?: Yes No

Yes No **Bleeding Disorder**
If Yes: Are you on blood thinners?: Yes No Type of bleeding problem _____

Yes No **Infectious Disease (Mono, Tuberculosis, Hepatitis, HIV/AIDS, Other?)**
If Yes: What disease?: _____ Year diagnosed: _____ Are you presently under treatment?: Yes No

Yes No **Immune System Disorder**
If Yes: Circle type Rheumatoid Arthritis Lupus (SLE) Psoriasis Immunosuppresive Drugs Other

Yes No **Heart Disease**
If Yes: Please circle: Cardiac Bypass Pacemaker Valve Replacement Heart Failure
Do you require antibiotic coverage for procedures? Yes _____ No _____

Yes No **Cancer**
If Yes: Type of Cancer: _____
Date Treated (Year): _____ Treated with (Circle ail that apply): Surgery Radiation Chemotherapy

Yes No **High Blood Pressure**

Past Surgeries:

1) _____ 2) _____ 3) _____

Continue on Next Page. Leave this space blank:

Both sides reviewed by Physician (sign) _____

Medical Office Building
2123 Auburn Ave. | Suite 209
Cincinnati, OH 45219
513.421.5558

Anderson
7691 Five Mile Rd | Suite 214
Cincinnati, OH 45230
513.232.3277

Kenwood
8250 Kenwood Crossing Way | Suite 210
Cincinnati, OH 45236
513.792.0000

Green Township
5885 Harrison Ave. | Suite 3700
Cincinnati, OH 45248
513.564.5090

Brown County Clinic
425 Home Street
Georgetown, OH 45121
937.378.7575

Family History

Please check if you have any known blood relatives with the following:

- ☐ Auto-Immune Disease (Rheumatoid/Lupus/Etc): If Yes: Type: _____ Relationship: _____
- ☐ Blood or Bleeding Disorder: Type: _____ Relationship: _____
- ☐ Nerve Disease: If Yes: Type: _____ Relationship: _____
- ☐ Muscle Disease: If Yes: Type: _____ Relationship: _____
- ☐ Bone Disease: If Yes: Type: _____ Relationship: _____
- ☐ Trouble with General Anesthesia: Type: _____ Relationship: _____
- ☐ Cancer: If Yes: Type: _____ Relationship: _____

Allergy Testing:

Have you been allergy tested? _____ Sensitive to (list): _____ , _____ , _____ , _____.

Did you receive allergy shots? _____ Dates? _____ Where? _____

Pets: _____

Review of Symptoms: Please check any that apply.

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Weight Change

Eyes:

- ☐ Blindness
- ☐ Double Vision / Blurred Vision
- ☐ Burning

Cardiovascular:

- ☐ Chest Pain
- ☐ Palpatations
- ☐ Irregular Heart Beats
- ☐ Ankle Edema or Swelling

Musculoskeletal:

- ☐ Joint Swelling
- ☐ Gout
- ☐ Muscle Aches

Neurological:

- ☐ Weakness
- ☐ Loss of Coordination
- ☐ Dizziness
- ☐ Headaches
- ☐ Seizures
- ☐ Tremors
- ☐ Stroke

Respiratory:

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Cough with Blood

Urinary:

- ☐ Prostate enlargement
- ☐ Obstruction from meds

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn or Reflux

Skin:

- ☐ Rash
- ☐ Skin Cancer
- ☐ Itching
- ☐ Change in Moles

Immunological:

- ☐ Food Sensitivity
- ☐ Asthma
- ☐ Recent Vaccinations

Emotional:

- ☐ Trouble Sleeping
- ☐ Anxiety
- ☐ Trouble Concentrating
- ☐ Mood Swings

Endocrine:

- ☐ Weakness
- ☐ Heat or Cold Intolerance
- ☐ Increased Thirst
- ☐ Frequent Urination
- ☐ Hair Loss

Hematological:

- ☐ Bleeding
- ☐ Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Anemia

General:

- ☐ Recent Travel Abroad
- ☐ Work exposures

Form Completed by: _____