

## **CHESAPEAKE RESEARCH GROUP, LLC**

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Chesapeake Research Group would like to thank you for your interest in participating in one of our clinical trials.

Enclosed is the registration and medical history forms we would like you to fill out in preparation for your first visit with our office. We are working alongside The Chesapeake Foot & Ankle Center, a Podiatry office, so completing the forms beforehand will expedite your initial visit with the doctor. Please use black or blue ink to complete the forms.

If you should have any questions or concerns regarding your visit, the clinical trial, or your paperwork please call 410-761-0118.

Thank you again for you interest, and we look forward to seeing you in our office on

\_\_\_\_\_ at \_\_\_\_\_.

Chesapeake Research Group, L.L.C.

**\*You may receive paperwork from Chesapeake Foot and Ankle, Chesapeake Ambulatory Center *and* Chesapeake Research Group.**

**\*\*Please come to Suite 104 (Chesapeake Research Group). Do not enter through Suite 100 (Chesapeake Foot And Ankle Center).**

**THE CHESAPEAKE FOOT & ANKLE CENTER, P.A.**

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

Patient Name \_\_\_\_\_  
Last First Initial

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Sex: \_\_\_ F \_\_\_ M

Cell Phone (\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Birth Date \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_ Marital Status \_\_\_\_\_

Social Security Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone Number (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

How did you hear about our facility?

- Health Fair                                       Internet                                       Doctor Referral  
 Friend/Family Member/Patient (Name: \_\_\_\_\_)  
 Ad (Source: \_\_\_\_\_)  
 Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_

I hereby give Drs. Gottlieb/Leone/Nguyen permission to examine and treat my feet/ankles via medical, surgical and/or orthopedic means.

Chesapeake Research Group, LLC will be responsible for paying approved study related medical or surgical services provided for 90 days from the date of surgery.

Signature of Patient/Responsible Party \_\_\_\_\_  
Date \_\_\_\_\_

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**Drs. Ira J. Gottlieb, Enzo J. Leone, and Jenny Nguyen**  
[www.chesapeakefootandankle.com](http://www.chesapeakefootandankle.com)  
Phone: (410) 768-5800 Fax: (410) 768-5806

**Main Office:**

Pasadena - 8028 Ritchie Highway, Suite 100 - Pasadena, MD 21122

**Other Office:**

Mercy Medical Center – 341 N. Calvert Street, Suite 300 - Baltimore, MD 21202

# Chesapeake Foot and Ankle Center

**Patient Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe Size \_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_ It occurs when? Morning Afternoon Evening Off and On All Day

Please list previous treatments (either prescribed or home remedies): \_\_\_\_\_

Percent spent daily on your feet: 20% 40% 60% 80% 100%

List sports/activities that you are currently active in: \_\_\_\_\_

**\*\*\*\*Family Physician (PCP):** \_\_\_\_\_

	Name	Address	Phone Number
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**Medical History:** please circle **P** (personal history) and/or **F** (family history).

- |   |  |   |
|---|--|---|
| P F Alcohol/Drug addiction/dependency                                   | P F Headaches / Migraines headaches      | P F Seizures/ Epilepsy                  |
| P F Alzheimer's / Dementia  | P F Hearing Problems                     | P F STD's (sexually transmitted ds.)    |
| P F Anemia - type _____   | P F Heart Disease                        | P F Sickle Cell Trait/Disease           |
| P F Arrhythmias - type _____  | P F Hepatitis A B C /Liver Disease _____ | P F Stroke/ TIA's                       |
| P F Arthritis - type _____  | P F High Blood Pressure                  | P F Thyroid problems<br>(Hyper__Hypo__) |
| P F Asthma circle( adult or childhood)                                  | P F High Cholesterol                     | P F Tuberculosis                        |
| P F Bleeding/Clotting Problems. Type?                                   | P F HIV/ Aids/ ARC                       | P F Other, Please Specify               |
| P F Cancer - type _____   | P F Kidney/ Renal Disease                | _____                                   |
| P F Depression / Anxiety disorder /<br>Bipolar depression / other _____ | P F Lung Disease/Pulmonary Embolus       | P F Other, Please Specify               |
| P F Diabetes (how long? _____)  | P F Lyme's Disease                       | _____                                   |
| P F Emphysema / COPD  | P F Nervous Condition (type?) _____      | _____                                   |
| P F Glaucoma  | P F Osteoporosis / Osteopenia (circle)   | P F <b>NONE of the above</b>            |
| P F Gout  | P F Phlebitis (blood clots in legs)      |   |
| P F GERD (Reflux) / GI ulcers (circle)                                  | P F Poor Circulation / PVD               |   |
|   | P F Rheumatic Fever / Scarlet Fever      |   |

**Have you been hospitalized? Y N Please list**

**Have you ever had surgery? Y N Please list**

Do you have a history of allergies/skin reaction/sickness following the administration of any of the following:

	Y	N	** If yes, list REACTION
Adhesive tape	—	—	_____
Anesthesia	—	—	_____
Aspirin	—	—	_____
Caffeine	—	—	_____
Codeine	—	—	_____
Cortisone	—	—	_____
Demerol	—	—	_____
Foods	—	—	_____
Iodine	—	—	_____
Latex	—	—	_____
Local Anesthetics	—	—	_____
Penicillin	—	—	_____
Sulfa Drugs	—	—	_____
Other, please list: _____			_____

**Woman:** Are you currently pregnant? YES NO  
Due date? \_\_\_\_\_

**Social History: PLEASE FILL OUT COMPLETELY**

**SMOKING:**  
Do you currently smoke? YES NO If yes, how many years? \_\_\_\_\_  
How long does a pack of cigarettes last you? \_\_\_\_\_  
Have you ever smoked? YES NO If yes, how many years? \_\_\_\_\_  
How long ago did you quit? \_\_\_\_\_

**ALCOHOL USE:**  
Do you currently drink alcoholic beverages? YES NO  
Do you drink some form of alcohol every day? YES NO  
How many drinks will you consume in a day? \_\_\_\_\_week? \_\_\_\_\_  
Do you have a history of drinking? YES NO If yes, how many years? \_\_\_\_\_  
How long ago did you quit? \_\_\_\_\_

**RECREATIONAL DRUG USE:**  
Do you currently use illicit/recreational drugs? \_\_\_\_\_  
If yes, which ones \_\_\_\_\_  
Have you ever used illicit/recreational drugs? If yes, please list below.  
\_\_\_\_\_  
How long ago did you quit? \_\_\_\_\_

**Consent for Treatment:**

I certify that the information above is true and correct to the best of my knowledge. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. I give permission to Drs. Gottlieb, Leone and Nguyen to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and ankles.

\_\_\_\_\_  
Patient or Guardian Signature  
\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Date

**Patients Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

## Medication/Surgery List

**Please list all medications you are currently taking including: aspirin, over the counter medications, herbal products and vitamins.**

Medication	Dose	Frequency	Start Date	Stop Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**Have you ever had surgery before? YES \_\_\_ NO \_\_\_**

**Have you ever been hospitalized? YES \_\_\_ NO \_\_\_**

**Please list all previous hospitalizations and surgeries:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**THE CHESAPEAKE FOOT AND ANKLE CENTER, P.A./  
CHESAPEAKE RESEARCH GROUP, LLC**

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES  
(Effective Date: April 14, 2003)**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice.

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Patient Name (please print)

Date

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Parent or Authorized Representative (if applicable)

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Signature

(\*\*NOTE: You have the right to refuse to sign this Form)

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Print Name

Date

For Professional Use Only

No signature above is for the following reason:

- Individual refused to sign
- Communication barrier prohibited obtaining a signed acknowledgment
- Emergency Services prohibited a signed acknowledgment
- Specify other reasons \_\_\_\_\_