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).

8028 Gov. Ritchie Highway, Suites 100-104
Pasadena, MD 21122
Phone: (410) 761-0118 Fax: (410) 761-5118
www.chesapeakeresearch.com

THE CHESAPEAKE FOOT & ANKLE CENTER, P.A.

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 _____

Drs. Ira J. Gottlieb, Enzo J. Leone, and Jenny Nguyen
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**_____
Last First MI

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

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

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

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 Date

_____ _____
Patient or Guardian Signature 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.

Patient Name (please print) Date

Parent or Authorized Representative (if applicable)

Signature

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

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 _____