Patient Label
환자바코드 부착 부분입니다

New Patient Information Form

환자정보조사지

Please complete this form with attachments and send to International Healthcare Center via **Zemyna's web site.**

Zemyna will only have the patient's information in the General Information section on this form plus the patient's MRI and X-Ray images and not any of the patients' other medical information submitted.

All of the requested information has to be provided for the hospital to determine whether the patient can have a CARTISTEM surgery.

Should you have any inquiry regarding this form, kindly contact International Healthcare Center
Email: ish2014feb@gmail.com

PLEASE COMPLETE AND SUBMIT THIS FORM WITH A COPY OF THE FOLLOWING :			
Document	**Confirm Attachment**	**Document**	**Confirm Attachment**
Copy of passport	☐	X-rays (Both Knees Long Bone, Hip-Ankle)	☐
Insurance Card (if available)	☐	MRI of Knee	☐
Note: If the patient has any form of heart disease, then please provide a knee surgery clearance letter from the patient's cardiologist addressed to the patient. ☐			

GENERAL INFORMATION 일반정보			
PATIENT NAME 환자명	*(AS LISTED ON IDENTIFICATION)*		
DATE OF BIRTH 생년월일	*YYYY-MM-DD*	**GENDER 성별**	☐ **FEMALE 여** ☐ **MALE 남**
NATIONALITY 국적			
PHONE NUMBER 전화번호 **MOBILE NUMBER**			
EMAIL 이메일			
ADDRESS 주소			
MARITAL STATUS 결혼여부			
HOME DOCTOR'S NAME			
DOCTOR'S OFFICE ADDRESS			
DOCTOR'S PHONE NUMBER			
Doctor's EMAIL 이메일			

NEXT OF KIN / EMERGENCY CONTACT 보호자 정보	
NAME 성명	
EMAIL 이메일	
PHONE NUMBER 전화번호 **MOBILE NUMBER**	
RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION 보험정보			
PATIENT NAME 환자명			
GENDER 성별	☐ **FEMALE 여** ☐ **MALE 남**	**DATE OF BIRTH 생년월일**	*YYYY-MM-DD*
EMPLOYER 회사명	***if available***		
INSURANCE COMPANY NAME	***if available***		
POLICY NUMBER 보험사 회원번호	***if available***		
GROUP/PLAN NUMBER 그룹/상품명	***if available***		

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CATHOLIC KWANDONG UNIVERSITY
INTERNATIONAL ST. MARY'S HOSPITAL

New Patient Questionnaire 환자문진표

Name 성명 :		**DOB** 생년월일 : ***YYYY-MM-DD***
Height 키 : ☐ **Feet** ___________ ☐ **Centimeters** ___________	**Weight** 몸무게 : ☐ **Pounds** ________ ☐ **Kilograms** ________	**Age** 나이 : ________ **GENDER** ☐ **FEMALE 여** ☐ **MALE 남**
Mid-Thigh circumference : *Please follow the instructions on the last page*		☐ **Centimeters_____ or** ☐ **Inches_____**
Occupation :		

Chief Complaint 주호소

What is reason for your visit? 병원 방문이유

Cartistem

Current Pain Level (No pain 0-10 highest) :

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

Previous Medical History 과거력 Boxes below should be set up so they can be simply clicked

Please select any past medical conditions below: 아래의 과거력에 해당되는 부분을 선택하세요

☐High blood pressure 고혈압	☐ Diabetes 당뇨
☐ Pulmonary Tuberculosis 결핵	☐ Hepatitis 간염
☐ Cancer 암	☐ Angina pectoris/Cardiac infarction협심증/심근경색
☐ Gastritis/ Duodenitis 위염/십이지장염	☐ Stroke 뇌졸중
☐ Gastric ulcer/ Duodenal ulcer 위궤양/십이지장궤양	☐ Renal disease / Bladder disease 신장/방광질환
☐ Disorder of Liver, functional 간질환	☐ Hematuria 혈뇨
☐ Fatty liver 지방간	☐ Thyroid disease 갑상선질환
☐ Hyperlipidemia 고지혈증	☐ Disc of neck or back 허리.목디스크
☐ Gallbladder stone 담석증	☐ Hearing disability 청력장애
☐ Polyp- rectal, colon 용종	☐ Glaucoma 녹내장
☐ Asthma 천식	☐ Cataract 백내장
☐ Breast disease 유방질환	☐ Myoma of the uterus 자궁근종
☐Osteoporosis 골다공증	☐ Others (Specify)

Family History 가족력

Please select medical conditions and list any family members(mother, father, sibling) below:

Disease	**Relation**	**Disease**	**Relation**
☐ High blood pressure		☐ Cancer	
☐ Pulmonary Tuberculosis		☐ Asthma	
☐ Diabetes		☐ Congenital Heart Disease	
☐ Pulmonary Tuberculosis		☐ Rheumatoid	
☐ Stroke		☐ Allergy	
☐ Hepatitis		☐ Colon Disease	
☐ Liver cirrhosis		☐ Others(Specify)	

Allergy(medicine, food, diet) 알러지	☐ **Yes** ☐ **No**
Types	**Reaction** 반응
1 Allergy to medicine	

2 Allergy to food	
3 Dietary Perfances	

Current Medication 현재복용약		☐ **Yes** ☐ **No**	
Medication	**Route(Oral,injection,etc.)**	**Dose**	**Frequency**
1			
2			
3			
4			
5			
6			
7			
8			

Surgical History 수술력	☐ **Yes** ☐ **No**
Previous Surgery 이전수술명	**Occurrence Date(approx.)** 시행일(대략)
1	
2	
3	
4	
5	

Social History 사회력	
Do you currently smoke tobacco? 현재흡연여부	☐ **Yes** ☐ **No**
If no, have smoked tobacco in the past? 과거 흡연경험	☐ **Yes** ☐ **No**
How old were you when you FIRST started to smoke? 흡연시작시기	
How long have you been smoking? 흡연기간	
On the average, how many cigarettes do you now smoke a day? 하루평균흡연량	
If you stopped smoking, when did you stop smoking? 흡연을 중단한 시기	
Do you consume alcohol?	☐ **Yes** ☐ **No**
If yes, how often do you have a drink containing alcohol? 음주횟수	_____ times per week
How many ounces or milliliters of beer, wine and or spirits do you have in a typical day? **평균 음주량** Beer milliliters __________ Ounces __________ Wine milliliters __________ Ounces __________ Spirits milliliters __________ Ounces __________	

Review of System
If you have recently had any symptoms listed below, please check. 최근 상태
Sudden change in weight 갑작스러운 체중변화 ☐ Weight loss 체중감소: ____________________ kg or pounds ________ for ____________________ (duration) ☐ Weight gain 체중증가: ____________________ kg or pounds ________ for ____________________

(duration)

Digestive system

☐ Indigestion 소화불량
☐ Burping (belching) 트림
☐ Pain in the chest 명치나 가슴통증
☐ Feel abdominal swelling (bloating) 배가 더부룩함
☐ Heartburn (fasting, after eating) 속쓰림
☐ Nausea, Vomiting 구역질, 구토증상
☐ Uncomfortable feeling in the throat 목의 이물감
☐ Stomachache 복통
☐ Pain in the right upper abdomen 우상복부 통증
☐ Diarrhea 설사
☐ Bloating, have gas 복부/가스팽만
☐ Constipation 변비
☐ Defecate frequently 잦은 배변
☐ Thin stools 변이 가늘다
☐ Bloody stools 혈변
☐ Black stool 검은변

Nervous system

☐ Frequent headaches 잦은 두통
☐ Absent-mindedness 일시적인 기억상실
☐ Paralysis 신체마비
☐ Tingling in the limbs 손발저림
☐ Dizziness 현기증
☐ Facial Paralysis 안면감각이상

Others

☐ Itchy skin 피부가려움증
☐ Hives 두드러기
☐ Poor vision 시력저하
☐ Pain in the eyes 눈이 아픔
☐ Hard of hearing 청력감소
☐ Ringing in the ears (tinnitus) 이명
☐ Ear discharge 귀 분비물
☐ Hoarseness 목소리가 자주 쉼

Cardiovascular system

☐ Shortness of breath 숨이 찬다
☐ Feel heavy in the chest when you exercise 운동 시 가슴이 답답
☐ Tightness in the chest 가슴이 조여오며 뻐근하다
☐ Shortness of breath when you lie down: if you sit up, it gets better 누우면 숨차고 앉으면 편해짐
☐ Irregular pulse rate. Palpitations 맥이 불규칙, 두근거린다

Respiratory system

☐ Frequent coughing 기침을 자주함
☐ Yellowish green sputum 황색이나 녹색 가래
☐ Bloody sputum 가래에 피가 섞여 나온다
☐ Difficulty breathing 숨이 차다
☐ Wheezing 숨쉴 때 쌕쌕거린다
☐ To be slow or the hand trembles 행동 느려지거나 손 떨림

Urinary system

☐ Difficulty urinating, feel feeling of residual urine 소변보기 힘들고 잔뇨감
☐ Cloudy urine 소변색 탁함
☐ Pain in the side of the lower abdomen 옆구리아랫배 통증
☐ Frequent night urination 야간에 잦은 소변
☐ Trouble holding urine 소변을 못 참음
☐ Blood in the urine 혈뇨
☐ Incontinence 요실금

☐ Dizziness 어지러움
☐ Frequent nosebleeds 코피 잘남
☐ Sharp pains in the joints, ache all over 뼈마디 쑤시고 아픔
☐ Joint movement disorder 관절운동 장애
☐ Bruise easily 멍이 잘 듬
☐ Gums bleeding 잇몸에서 피가 남
☐ Bad breath 구취
☐ Toothache 치통

How to measure your mid-thigh circumference(for knee brace size)

First mark the site to be measured. This girth measurement is usually taken on the right side of the body. The subject stands erect with their weight evenly distributed on both feet and legs slightly parted. The circumference measure is taken at the level of the mid-point on the lateral (outer side) surface of the thigh, midway between the Inguinal crease (top of the thigh bone, femur) and proximal border of patella. When recording, you need to make sure the tape is not too tight or too loose, is lying flat on the skin, and the tape held horizontal.

Inguinal crease

Crease of Hip

Mid-thigh

Proximal border of patella

To the best of my knowledge, the above information is correct:

__________________________________ ____________________ _____/_____/____

Print name of patient **Signature** **Date yyyy/mm/dd**