EDWARD K. PANG MEDICAL CORPORATION

EDWARD K. PANG, D.O.

www.DrEdwardPang.com

Tel: (310) 248-7358 Fax: (310) 248-7379

NEW PATIENT INFORMATION

Last Name: ______________________ First Name: _____________________ MI: ____

Preferred Name: __________________

Street Address: ____

City: ____________________________ State: _______ Zip: _______

Preferred Phone #: ________________________ E-mail Address: ________________________

Date of Birth: ___________ Age: _____ Sex at birth: _________ Gender: ____________

Occupation: ______________________________ Employer: _______________________

Emergency Contact (relationship): _____________________________ Phone #: _________________

Primary Care Physician: _____________________________________ Phone #: _________________

Referred by: ____ Phone #: _________________

If not referred by a doctor, how did you hear about Dr. Pang?

____

Has any member of your immediate family been treated by Dr. Pang before?

____

Primary Insurance Carrier: ____________________________ Insurance ID #: ______________

Secondary Insurance Carrier: __________________________ Insurance ID #: ______________

SSN: _________________________ Driver's License #: ____________________________

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of Insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128b of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare Assignment of benefits also apply.

Signature: __________________________________ Date: _________________

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PAIN DIAGRAM

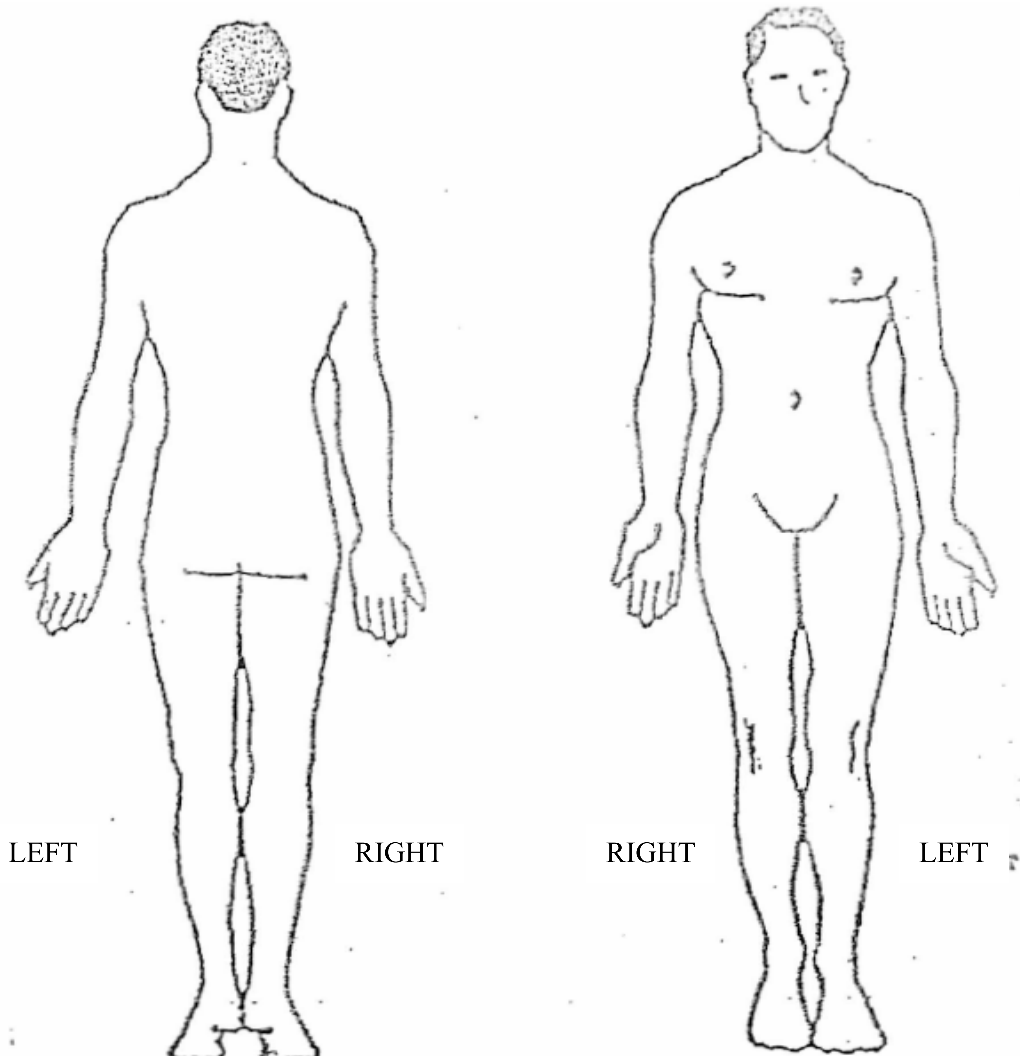
NAME: ______________________________ DATE: _____________ AGE: _______

Where is your pain?

____

Mark the areas on the diagram below using the appropriate symbols where you feel the described sensation.

PAIN ^ ^ ^ **NUMBNESS O O O** **TINGLING X X X** **RADIATING PAIN / / /**



On a scale of 0-10 (0 being no pain, 10 being the worst pain), how bad is your pain?

BACK PAIN: ____________

LEG PAIN: ____________

NECK PAIN: ____________

ARM PAIN: ____________

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NEW PATIENT QUESTIONAIRE

PATIENT NAME: ________________________________ DOB: _______________

Is your pain work related? ☐ Yes ☐ No

Are legal actions pending? ☐ Yes ☐ No If yes, provide attorney's office name and phone number:

____

Where is your pain? ___________________________ ☐Left ☐Right

What is your ***pain level 0-10*** with 10 being the worst pain? _________ ***When*** did your pain start? ____________

How did your pain start? ____

Describe your pain:

☐Burning ☐Sharp / shooting ☐Dull / Ache ☐Pressure ☐Stabbing ☐Tingling

☐Numbness ☐Spasms ☐Pinprick ☐Other: ______________________

Is your pain ***constant or intermittent*** (comes and goes)? ☐Constant ☐Intermittent

Does your pain ***radiate*** to a limb?

☐Upper Extremity ☐Right ☐Left Specify location: ____________________

☐Lower Extremity ☐Right ☐Left Specify location: ____________________

What makes the ***pain worse***?

☐Sitting ☐Standing ☐Walking ☐Stairs ☐Rising up ☐Bending forward

☐Bending backward ☐Twisting ☐Reaching ☐Lying down ☐Sneezing/coughing

☐Lifting ☐Other: _________________________________

What makes the ***pain better***?

☐Sitting ☐Standing ☐Walking ☐Stairs ☐Rising up ☐Bending forward

☐Bending backward ☐Twisting ☐Reaching ☐Lying down ☐Heat ☐Ice

☐Medications: ____________________ ☐Other: _____________________

Have you had any ***recent falls***? ☐ Yes ☐ No If yes, when was the last time? _________________

Do you have any ***trouble with buttoning shirt/pants***? ☐ Yes ☐ No Are you ***dropping things***? ☐ Yes ☐ No

Do you have any ***bowel or bladder incontinence or retention***? ☐ Yes ☐ No

Please indicate what ***treatments*** you have had for this and circle any treatments that have helped?

☐Physical Therapy ☐Chiropractic ☐Acupuncture ☐Ice ☐Heat ☐Massage ☐TENS

☐Epidurals ☐Facet injections ☐Radiofrequency ablation ☐Sacroiliac joint injection

☐Joint injection ☐Spinal cord stimulation ☐Other: ____

☐Bracing: ____

☐Medications (including over-the-counter meds): ____

☐Surgery: ____

☐Other: ____

Have you had any of the ***following studies*** for this? ☐MRI ☐X-ray ☐EMG/NCS ☐CT

If yes, where and when were these done? ____

How is your pain ***interfering*** with your life? ☐Work/School ☐Walking ☐Activities of daily living

☐Social activities ☐School ☐Other: ____

Are you currently ***working***? ☐Yes ☐No

Do you use any ***assistive device*** to walk? ☐Cane ☐Walker ☐Wheelchair ☐Others:____________________

If so, how long have you been using it? ____________

How much ***physical activities*** do you normally do? ____

Do you have any other ***medical problems***?

- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clot
- ☐ Cancer
- ☐ Chronic back pain
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ GI bleed
- ☐ Heart Attack
- ☐ Hepatitis A/B/C
- ☐ High blood pressure
- ☐ HIV
- ☐ Hypothyroidism
- ☐ Irregular heart beat
- ☐ Kidney failure
- ☐ Liver problems
- ☐ Lupus
- ☐ Migraines
- ☐ Neurological disorder
- ☐ Numbness/tingling
- ☐ UTI
- ☐ Poor circulation
- ☐ Pulmonary embolism
- ☐ Reflux
- ☐ Rheumatoid arthritis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ PUD
- ☐ Unremarkable
- ☐ Others:______ ______________

Any ***other surgery*** in the past not listed above? ____

Allergies and reaction: ____

Are you allergic to ☐ latex ☐ surgical tape ☐ contrast medium ☐ shellfish

Are there any medical problems in your family? ____

____

Social History

Tobacco use: ☐ Yes; how many packs a day_____ ☐ No ☐ Quit: When?___________

Alcohol use: ☐ Yes; how many drinks a day_____ ☐ No ☐ Quit: When?___________

Recreational drug use: ☐ Yes; what type:_______________ ☐ No ☐ Quit: When?___________

Marital status: __________________________ Children: ☐ Yes; how many_______ ☐ No

REVIEW OF SYSTEMS

(Please indicate the conditions that are applicable to you)

GENERAL
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia

EYES
- ☐ Blurring
- ☐ Double vision
- ☐ Vision loss
- ☐ Eye pain
- ☐ Light sensitivity

EARS/NOSE/THROAT
- ☐ Earache
- ☐ Tinnitus
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Dysphagia

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Syncope
- ☐ Dyspnea
- ☐ Orthopnea
- ☐ Peripheral edema

RESPIRATORY
- ☐ Cough
- ☐ Dyspnea
- ☐ Excessive sputum
- ☐ Hemoptysis
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel
- ☐ Abdominal pain
- ☐ Melena
- ☐ Hematochezia
- ☐ Jaundice

GENITOURINARY
- ☐ Dysuria
- ☐ Hematuria
- ☐ Discharge
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Nocturia
- ☐ Incontinence
- ☐ Genital sores
- ☐ Impotence
- ☐ Decreased libido

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Dryness
- ☐ Suspicious lesions

NEUROLOGIC
- ☐ Weakness
- ☐ Paresthesias
- ☐ Seizures
- ☐ Syncope
- ☐ Tremors
- ☐ Vertigo

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Mental disturbance
- ☐ Suicidal ideation
- ☐ Homicidal ideation
- ☐ Hallucinations
- ☐ Paranoia

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Polyuria
- ☐ Weight change

HEME / LYMPHATIC
- ☐ Abnormal bruising
- ☐ Bleeding
- ☐ Enlarged lymph nodes

IMMUNOLOGIC
- ☐ Urticaria
- ☐ Hay fever
- ☐ Persistent infections
- ☐ HIV exposure

All other medications including supplements and herbal medications: ________________________________

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PLEASE SEND COMPLETED FORM TO info@DrEdwardPang.com OR FAX: 310-248-7379
OTHERWISE BRING COMPLETED FORM WITH YOU