EDWARD K. PANG MEDICAL CORPORATION
EDWARD K. PANG, D.O.
www.DrEdwardPang.com
Tel: (310) 248-7352 Fax: (424) 314-8595

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 staff. Some services are not covered by insurance and are available on a cash-only basis, of which the patient will be informed in advance. For these services, the patient assumes full financial responsibility for the total amount rendered and claims will not be submitted to insurance. We value everyone's time; therefore, if an appointment is canceled within 24 hours or no show for an appointment (15 minutes late to an appointment is considered a no show), a $30 fee will be applied to the patient. Your understanding and cooperation are greatly appreciated.

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: _____

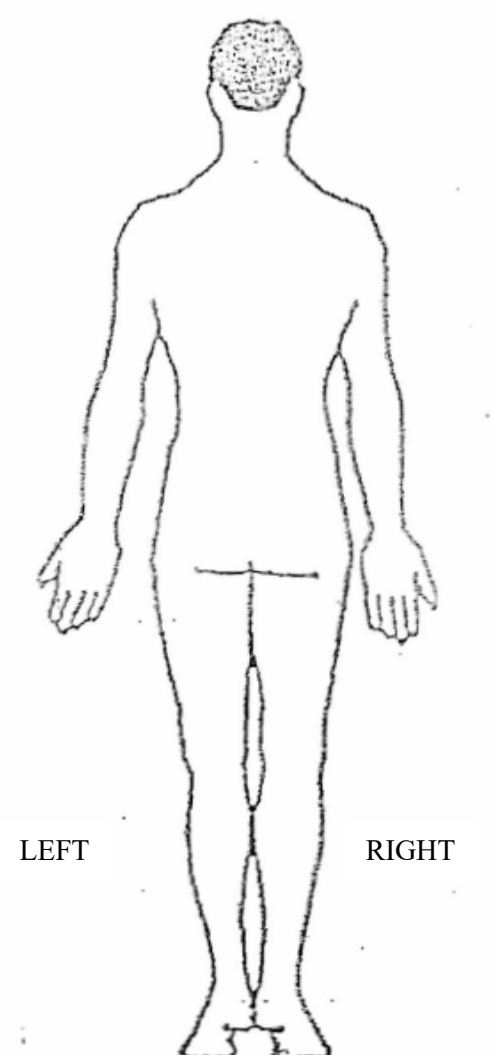
Where is your pain?

_____

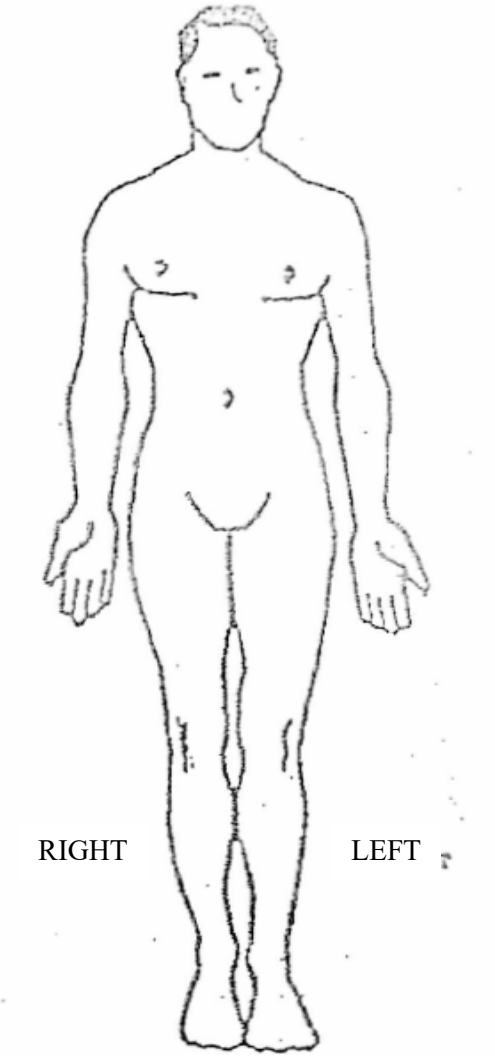
Mark the areas on the diagram below using the appropriate symbols where you feel the described sensation.

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

BACK



FRONT



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: _____

_____

_____

PLEASE SEND COMPLETED FORM TO info@DrEdwardPang.com OR FAX: 424-314-8595
OTHERWISE BRING COMPLETED FORM WITH YOU

Submit