EDWARD D. WANG, M.D.

EXISTING PATIENT – NEW TREATMENT /INJURY INFORMATION

DATE: ________________ Dominant Hand: RIGHT or LEFT

NAME: ____ DOB: _________________

PHONE: (HOME) ______________PHONE: (WORK) ____________ CELL :____________________

AGE: ________________________ EMAIL:____

OCCUPATION: _________________________ TYPE OF INSURANCE:_________________________

REFERRING PHYSICIAN: PRIMARY CARE PHYSICIAN

_________________________________ _____________________________

PHONE: __________________________ PHONE: ______________________

WHAT IS THE PURPOSE OF YOUR VISIT TODAY? ____

____

WHEN DID THE PROBLEM START? HOW? ____

HAVE THERE BEEN ANY CHANGES IN YOUR MEDICAL CONDITION SINCE YOUR LAST VIST:

NO:________ IF YES :DETAILS_________________________

____

ANY CHANGE TO MEDICATIONS TAKEN: NO:_________IF YES: DETAILS ____________________________

____

IS THIS A WORK RELATED ACCIDENT? YES:________ NO: __________WHEN:__________________

IF YES, HOW IS IT WORK RELATED? ____

WAS AN AUTOMOBILE INVOLVED? YES:________ NO: __________WHEN: ___________

ARE YOU PRESENTLY WORKING? YES: ________NO:__________

IF YOU WERE/ARE UNABLE TO WORK, PLEASE LIST DATES OF DISABILITY BELOW:

FROM DATE: ________________________ TO DATE: ______________________________________

DETAIL YOUR TREATMENT AND PROGRESS TO DATE: _______________________________________

____

PLEASE RATE YOUR PAIN ON A SCALE OF 0 TO 10, 1 BEING THE LEAST AMOUNT OF PAIN AND 10 BEING THE HIGHEST PAIN: 1 2 3 4 5 6 7 8 9 10

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PATIENT NAME: ____

SIGNATURE____ DATE: __________________