Office Location: Stony Brook Orthopaedic
14 Technology Drive, Suite 11
E. Setauket, NY 11733
Appointments: 631-444-4233 option 1

EDWARD D. WANG, M.D.
INITIAL PATIENT INFORMATION

DATE: _____ **Dominant Hand: RIGHT or LEFT**

NAME: _____ **DOB:** _____

PHONE: (HOME) _____ **PHONE: (WORK)** _____ **CELL :** _____

AGE: _____ **EMAIL:** _____

ARE YOU: **MARRIED:** _____ **DIVORCED:** _____ **SINGLE:** _____

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? _____

_____

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: _____

_____

HEIGHT: _____ **WEIGHT:** _____

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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

PAST HISTORY:++

OPERATIONS: (WITH DATES)_____

MEDICAL ILLNESSES: _____

DRUG ALLERGIES: _____

REGULAR MEDICATIONS TAKEN: _____

_____

FAMILY ILLNESSES (PARENTS, GRANDPARENTS, ETC) _____

_____

DO YOU DRINK ALCOHOLIC BEVERAGES? _____ IF YES, HOW MUCH?_____

DO YOU SMOKE? _____ IF YES, HOW MUCH?_____

DO YOU USE ANY DRUGS FOR NON-MEDICAL PURPOSES? _____ IF SO, WHAT TYPE_____
(IF PREFERRED, YOU MAY COMMUNICATE THIS INFORMATION DIRECTLY TO THE DOCTOR)

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

_____ STOMACH PROBLEMS_____HEART DISEASE_____LUNG DISEASE _____DIABETES _____GOUT

_____HIGH BLOOD PRESSURE ____VESSEL DISEASE ____BLEEDING_____CANCER _____ARTHRITIS

_____KIDNEY PROBLEMS _____INTESTINAL DISEASE _____EPILEPSY _____SEXUAL DIFFICULTIES

_____PSYCHIATRIC ILLNESS _____BOWEL OR BLADDER PROBLEMS _____OTHER(PLEASE EXPLAIN)

OTHER: _____

++

PATIENT NAME: _____

SIGNATURE_____ DATE: _____