Main Line HealthCare
Physician Network

Main Line Health Orthopaedics & Spine

New patients of David N. Vegari, MD
Please complete the 3-page form and answer the following questions to the best of your ability.

NAME:_____ DATE:_____

AGE:_____ CURRENT WEIGHT:_____ CURRENT HEIGHT:_____

OCCUPATION AND WORKPLACE:_____

ARE YOU CURRENTLY WORKING: _____ IF NOT WHEN DID YOU STOP? _____

IF NOT WORKING, PLEASE EXPLAIN WHY?_____

DATE OF INJURY OR ONSET OF SYMPTOMS:_____

FAMILY DOCTOR NAME AND ADDRESS:_____

PHYSICIAN WHO SENT YOU HERE:_____

PLEASE LIST ALL PHYSICIAN SPECIALISTS THAT YOU SEE:_____

_____

_____

REASON FOR VISIT: (Please explain **which side**, **how** and **when** things began, describe your symptoms and severity, **what** makes your symptoms better or worse, are things getting any better or worse, any **tests** or **treatment** you may have had for this problem, etc.)

_____

_____

_____

_____

_____

_____

PLEASE LIST ALL MEDICAL PROBLEMS WITH THEIR CORRESPONDING MEDICATIONS (ex: hypertension, diabetes, etc.)

MEDICATIONS:	**ASSOCIATED MEDICAL PROBLEM**:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PAGE 2 NAME:_____ DATE:_____

PLEASE LIST ALLERGIES TO MEDICATIONS: (DESCRIBE REACTION FOR EACH):

_____

_____

_____

ARE YOU ALLERGIC TO TAKE, IODINE, OR LATEX? _____

PLEASE LIST ALL MAJOR SURGERIES YOU HAVE HAD, INCLUDING DATES AND SIDE (LEFT OR RIGHT):

_____

_____

_____

_____

DO YOU SMOKE?_____YES _____NO HOW MANY PACKS PER DAY?_____

HAVE YOU EVER SMOKED? (HOW MUCH AND FOR HOW LONG)_____

IF YES, WHEN DID YOU QUIT?_____

DO YOU DRINK? _____YES _____ NO HOW MUCH?_____

HAVE YOU EVER HAD A DRUG OR ALCOHOL PROBLEM? _____

PLEASE LIST ALL MAJOR DISEASES THAT RUN IN YOUR FAMILY:

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please explain all YES answers.

Have you ever had a problem taking aspirin, Motrin, or other arthritis type medication?

_____

Have you had a history of recent fevers, sweats, chills, or weight loss?

_____

Have you had any problems with your heart or blood pressure?

_____

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PAGE 3 NAME:_____ DATE:_____

REVIEW OF SYSTEMS - *Continued*

Please explain all YES answers.

Have you had any problems breathing or lung problems (ex: asthma, emphysema, cough, etc)?

_____

Have you had any problems with digestion or bowel problems?

_____

Have you had any problems with kidney or bladder function (ex: kidney stones, problems with urination)?

_____

Have you had any problems with other joint or muscles? (arthritis, gout, osteoporosis, etc)?

_____

Have you had any problems with your skin? (rashes, etc)?

_____

Have you had any neurological problems (ex: stroke, seizure, dizziness, nerve, or headache)?

_____

Have you had any endocrine (hormonal) problems such as diabetes (sugar, thyroid, etc)?

_____

Have you had any problems with anemia, bleeding, or other blood problems?

_____

Do you have a history of intestinal bleeding?

_____

Do you have any liver problems (hepatitis, jaundice, etc)?

_____

Have you had any problems with your eyes?

_____

Have you had any problems with your ears, nose, throat, or mouth?

_____

Please list any other health problems not already mentioned

_____

_____ _____

YOUR SIGNATURE PHYSICIAN SIGNATURE