Main Line HealthCare
Physician Network

Main Line Health Orthopaedics & Spine at Lankenau Medical Center

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.)

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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):

____

____

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____

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:

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 NAME:________________________________ DATE:___________________

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?

____

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 DAVID N. VEGARI, MD