DR. RICHARD DIMARIO MEDICAL SUMMARY

NAME: EMAIL:

MAILING ADDRESS:

PERMANENT ADDRESS:

EMPLOYER NAME/ADDRESS:

HOME PHONE: CELL PHONE: WORK PHONE:

DATE OF BIRTH: MARITAL STATUS:

HOW DID YOU HEAR ABOUT DR. DIMARIO INTERNET/GOOGLE FRIEND/FAMILY PHYSICIAN REFERRAL

HOW DID YOU HEAR ABOUT DR. DIMARIO INSURANCE YORK HOSPITAL OTHER

NAME OF HEALTH INSURANCE: NAME OF PRIMARY CARE:

IS THIS YOUR FIRST VISIT TO A PODIATRIST: YES NO

WHAT IS THE PROBLEM WITH YOUR FEET?

DO YOU CURRENTLY SMOKE CIGARETTES: YES NO HAVE YOU EVER SMOKED IN THE PAST? YES NO

DO YOU DRINK ALCOHOL? YES NO / WINE BEER LIQUOR HOW MUCH?

PLEASE CIRCLE ANY OF THE FOLLOWING DISEASES THAT PERTAIN TO YOU:

Diabetes	Angina	Heart Failure	Heart Attack	High Blood Pressure
Stroke	Cancer	HIV Positive	Aids	Rheumatic Fever
Gout	Glaucoma	Emphysema	Osteoarthritis	Circulation Problems
Psoriasis	Hepatitis	Raynaud's disease	Atrial Fibrillation	Buerger's Disease
Bronchitis	Cirrhosis	Jaundice	Kidney stones	Lyme Disease
Lupus	Alzheimer's	Stomach Ulcers	Parkinson	Cholesterol
Colitis	Syphilis	Osteoporosis	Fibromyalgia	Intestinal Problems
Alcoholism	Phlebitis	Drug Addition	Hypothyroid	Hyperthyroid
Depression	Neuropathy	COPD	Multiple Sclerosis	Thyroid disease
Asthma		Epilepsy/Seizures	Rheumatoid Arthritis	GERD

LIST ANY OTHER DISEASES :

LIST MEDICATIONS AND DOSAGES:

LIST ANY MAJOR SURGICAL PROCEDURES:

HAVE YOU EVER BROKEN ANY BONES OR HAD SERIOUS INJURIES TO YOUR FEET OR LEGS? YES NO

ARE YOU ALLERGIC TO PENICILLIN? YES NO ALLERGIC TO ADHESIVE TAPE? YES NO

ANY OTHER DRUG ALLERGIES? YES NO IF YES, PLEASE LIST:

IS THERE A HISTORY OF DIABETES IN YOUR FAMILY? YES NO BROTHER SISTER MOTHER FATHER

HEIGHT: WEIGHT: BLOOD PRESSURE: /

IN CASE OF EMERGENCY PLEASE CALL:

I HAVE GIVEN DR. DIMARIO PERMISSION TO EXAMINE ME AND PROVIDE TREATMENT AND MINOR PROCEDURES, AS HE DEEMS NECESSARY.

SIGNED: _____ DATE: _____