DR. RICHARD DIMARIO		MEDICAL SUMMARY		
NAME:		**EMAIL:**		
MAILING ADDRESS:		**CITY STATE ZIP:**		
PERMANENT ADDRESS:		**CITY STATE ZIP:**		
EMPLOYER NAME/ADDRESS:				
HOME PHONE:	**CELL PHONE:**		**WORK PHONE:**	
DATE OF BIRTH:	**MARITAL STATUS:**			
HOW DID YOU HEAR ABOUT DR. DIMARIO: (CIRCLE) INTERNET/GOOGLE FRIEND FAMILY REFERRAL				
	FACEBOOK YORK HOSPITAL INSURANCE OTHER			
NAME OF HEALTH INSURANCE:		**PRIMARY CARE DR:**		
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 SMOKE 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	MIGRAINES	HIGH BLOOD PRESSURE
STROKE	CANCER	HIV	AIDS	RHEUMATIC FEVER
GOUT	GLAUCOMA	EMPHYSEMA	OSTEOARTHRITIS	CIRCULATION PROBLEMS
PSORIASIS	HEPATITIS	RAYNAUD'S	A - FIB	BUERGER'S DISEASE
BRONCHITIS	CIRRHOSIS	JAUNDICE	KIDNEY STONES	LYME DISEASE
LUPUS	ALZHEIMERS	STOMACH ULCER	PARKINSONS	CHOLESTEROL
COLITIS	SYPHILLIS	OSTEOPORSIS	FIBROMYALGIA	INTESTINAL PROBLEMS
ALCOHOLISM	PHLEBITIS	SUBSTANCE ABUSE	THYROID	GRAVES DISEASE
DEPRESSION	NEUROPHATHY	COPD	MS	GERD
ASTHMA	COVID	SEIZURES	RA	TINNITUS
HEART MURMER	HEARING LOSS	EPILEPSY	KIDNEY DISEASE	BPH
LIST ANY OTHER DISEASES:				
LIST MEDICATIONS AND DOSAGES:				
MAJOR SURGICAL PROCEDURES:				
ARE YOU ALLERGIC TO PENICILLIN? YES/NO		**ALLERGIC TO ADHESIVE TAPE? YES/NO**		
ANY OTHER DRUG ALLERGIES?				
IS THERE A HISTORY OF DIABETES IN YOUR FAMILY? YES/NO BROTHER/SISTER/MOTHER/FATHER				
HEIGHT:	**WEIGHT:**	**BLOOD PRESSURE:**		
IN CASE OF EMERGENCY CALL:			**PHONE:**	
I GIVE DR. RICHARD DIMARO PERMISSION TO EXAMINE ME AND PROVIDE TREATMENT.				
SIGNED: _____ DATE: _____				
PARENT / LEGAL GUARDIAN				