The Mobile Foot Doctor
Joel DiSanti, D.P.M.

Health Information:

Patient's Name, please print: _____

Date of Birth: _____ Last four of Social Security Number: _____

Shoe Size: _____

Blood Pressure: _____/_____ Height:_____ Weight: _____

Please mark if you are being treated for any of the following

Eyes/Ears/Nose/Throat: ____Glaucoma ____Eye Disease ____Sinuses ____Difficulty Swallowing ____Bleeding ____Lumps or Masses ____Dental Infections ____None Heart/Circulation: ____Blood Pressure ____Heart Disease ____Vascular/Circulation ____Blood Clots ____Stroke ____None Respiratory: ____Emphysema ____Asthma ____Shortness of Breath ____Exercise Intolerance ____Tuberculosis ____None	Intestinal: ____Ulcers ____Colitis ____Liver Disease ____None Genitourinary: ____Incontinence ____Prostate ____Bladder difficulties ____None Endocrine: ____Diabetes ____Thyroid ____Kidney Problems ____None Muscle/Skeleton: ____Autoimmune Disease ____Degenerative Arthritis ____Joint Pain ____Tendon/muscle Injury ____Broken Bones ____None	Nervous System: ____Numbness ____Burning ____Tingling ____Seizures ____None Skin: ____Blisters ____Rashes ____Sores ____Growths ____None Psychiatric: ____Depression ____Anxiety ____Nervousness ____None Blood/Lymphatic: ____Anemia ____Bleeding Disorders ____Lymph Disease ____None

Other:

_____

_____

_____

_____

_____

Smoke? ____Yes ____No If quit, when? _____

Alcohol Use? ____Yes ____No

If yes, how much, how often?_____

History of substance abuse? ____Yes ____No

If yes what? _____

Prior Surgeries and Hospitalizations

Year	Surgeries/Hospitalizations	Reason

Family History
Please list the medical problems members in your family have had;

Diagnosis			Relationship to you
Heart Disease	____Yes	____No	_____
Stroke	____Yes	____No	_____
Kidney Disease	____Yes	____No	_____
Cancer	____Yes	____No	_____
Autoimmune	____Yes	____No	_____
Diabetes	____Yes	____No	_____
Neurological	____Yes	____No	_____

Please list all medications/Supplements/Vitamins you are taking

Medication	Dose	How often taken, twice/day, once/week…

Allergies

Allergy	What happens

Please tell me about your foot and/or ankle problem(s):

_____

_____

_____

_____

_____

When did the problem start?_____

Did the problem develop: _____ gradually _____ suddenly?

Does the problem come and go? _____Yes _____No

Is there anything that improves the problem? _____

Is there anything that makes it worse? _____

Is the problem work related? ____Yes ____No

Have you been treated by another Podiatrist? ____Yes ____No If yes;

Date last seen: _____

Dr's Name: _____

Please list previous treatments, if any:

_____

_____

_____

_____

If you have had any recent testing done concerning you foot problem(s), please try to obtain a copy of the report before our visit. This may be a x-ray report, MRI report and so on.

Date:_____ Time:_____

Signature of patient or legal guardian: _____

Print Name of legal guardian if applicable: _____