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Carla Di Gioia

BSc, DPM, AACFAS - Doctor of Podiatric Medicine

Patient Name: _____ Date: _____

Condition: PLEASE CHECK BOX next to each condition.

- | | |
|--|---|
| <input type="checkbox"/> plantar fasciitis/heel pain | <input type="checkbox"/> warts |
| <input type="checkbox"/> wound/ulceration | <input type="checkbox"/> laser for warts |
| <input type="checkbox"/> skin/nail condition | <input type="checkbox"/> ingrown toenail |
| <input type="checkbox"/> sports related injury | <input type="checkbox"/> bunion |
| <input type="checkbox"/> flatfoot | <input type="checkbox"/> hammertoe |
| <input type="checkbox"/> high arches | <input type="checkbox"/> diabetic foot care |
| <input type="checkbox"/> pediatric foot condition | <input type="checkbox"/> onychomycosis <input type="checkbox"/> laser |
| <input type="checkbox"/> custom made orthotics | <input type="checkbox"/> compression stockings |
| <input type="checkbox"/> other conditon | <input type="checkbox"/> night splint |

Comments: _____

Physician's name & signature: _____