

**Welcome To Our Office  
Dr. Esther Lyon**

Today's Day:			
<b>PATIENT INFORMATION</b>			
Patient Name:		Street Address	
City:	State:	Zip Code:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:		Age:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated			
Occupation:		Employer:	
Home#:	Work#:	Cell#:	
Best time and place to reach you:			
Who may we thank for referring you:			
<b>PERSON TO NOTIFY IN AN EMERGENCY</b>			
Name:		Relationship:	
Home#:	Work#:	Cell#:	
<b>PODIATRIC HISTORY</b>			
Describe your foot and/or ankle problem:			
Is this a work related injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How long has it been bothering you? (Describe in days, weeks or years)			
Describe any other past problems of your feet and/or ankles?			
Have you been treated by podiatrist before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Visit:	
If yes, please list Name:			
<b>GENERAL HEALTH INFORMATION</b>			
Blood Pressure:	Height:	Weight:	Shoe Size:
Athletic activities in which you participate (please list and indicate frequency):			
Cigarette/tobacco use: <input type="checkbox"/> Yes <input type="checkbox"/> No      Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No      How frequent?			
Do you use illegal substances for either medical or recreational purpose? If yes, please list:			
Family Doctor Name & Phone #		Last Visit:	
Are you now, or have you been, under any doctor's care for any reason over the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, please explain:			
List Surgeries you have had (indicate year)			
List hospitalizations other than the surgeries listed (indicate year)			
<b>ALLERGIES</b>			
Please list any allergies to medications or foods (i.e. Penicillin, Sulfa, Iodine, local anesthesia, shell fish, tape etc...)			
<input type="checkbox"/> No, I do not have any allergies to any <b>MEDICATIONS</b> that I am aware of			
<input type="checkbox"/> No, I do not have any allergies to <b>FOODS</b> that I am aware of			
<b>MEDICATIONS</b>			
Please list any medications currently taking, including prescriptions, over-the-counter and vitamins:			
Pharmacy Name:			
<b>INSURANCE</b>			
Please provide a copy of Primary, Secondary and Tertiary Insurance cards. <b>Policy holder's Name and Date of Birth REQUESTED TO FILE CLAIMS</b>			
NAME: _____		DATE OF BIRTH: _____	
<b>OVER</b>			