

East End Plastic Surgery & Laser Center  
Judy Ann Emanuele, M.D., F.A.C.S.

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Drug/Latex Allergies \_\_\_\_\_ Current Medications \_\_\_\_\_

Reason for seeing Dr. Emanuele today? \_\_\_\_\_

How did you hear about Dr. Emanuele? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Have you in the past? \_\_\_\_\_ # of packs a day \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you take aspirin, blood thinner, or aspirin containing products? \_\_\_\_\_

Do you take any vitamins or herbal supplements? \_\_\_\_\_

Is there anything about your health that Dr. Emanuele should be aware of? \_\_\_\_\_

Have you ever had plastic surgery? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Were you happy with the result? \_\_\_\_\_

Please check all that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Breast Disease           |
| <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Tendency        |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Asthma                   |
| <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anemia                   |
| <input type="checkbox"/> Thyroid Disorder      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Dryness of Eyes          |
| <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Problems Scarring        |
| <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Emotional Problems  | <input type="checkbox"/> Cancer, if yes what type |
| <input type="checkbox"/> Eye Itching/Burning   | <input type="checkbox"/> Eye Disease         | _____   |

Pertinent Family History: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_