

East End Plastic, Reconstructive, & Hand Surgery, P.C.
Judy Ann Emanuele, M.D., F.A.C.S.

Primary Care Physician _____ Phone # _____

Date of last physical examination _____ Height _____ Weight _____

Allergies _____ 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: ____/____/____