



Emily Hu, M.D.

Aesthetic and Reconstructive Plastic Surgeon

PATIENT INFORMATION

Date: _____

Patient Name: _____

Phone: (hm) _____

Address: _____

(cell) _____

City/State/Zip: _____

Email Address _____

Drivers License #: _____

Height: ___ ft ___ in Weight: ___ lbs

Birthdate: ___/___/___ Age: ___ Sex: Male or Female SSN: ___-___-___

Employer: _____ Phone #: _____

Occupation: _____

Emergency contact person and phone #: _____

REASON FOR INITIAL VISIT: _____

HOW DID YOU HEAR ABOUT US? Circle all that apply

Self - Friend/Family - Phone Book - Magazine - Newspaper - Internet - Physician

If you found us on the internet, which website did you find us on?

Plasticsurgery.org - Loveyourlook.com - Implantinfo.com - ILoveLO.com

Google - Yahoo - Facebook or other: _____

Referring Doctor (name): _____ Primary Care Physician (name): _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone Number: _____ Phone Number: _____

INSURANCE INFORMATION:

SUBSCRIBER INFORMATION IS REQUIRED

Relationship to patient: Self Spouse Child Other: _____

Subscriber Name: _____ Phone #: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____

Secondary Insurance: _____

Policy holders Name: _____

Policy holders name: _____

ID#: _____

ID#: _____

Group #: _____

Group #: _____

Address: _____

Address: _____

Phone #: _____

Phone #: _____

Signed: _____

Date: _____

Patient's signature/Guardian Signature

**AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION**

Please list all surgeries, serious injuries, illnesses or diseases:

Type	Year	Surgeon/Physician	City/State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies: (example: Penicillin, sulfa, iodine, seafood, codeine, anesthesia, tape, eggs)

NO ALLERGIES _____

Food/Drug	Reaction
_____	_____
_____	_____
_____	_____

Current Medications: (please include herbal supplements or over-the-counter remedies)

Name of drug	Dose (mg)	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Conditions, which seem to run in your family. For example, heart attacks, blood clots, diabetes, etc:

_____	_____
_____	_____
_____	_____

Do you smoke? Yes No How much? _____

Do you use drugs: Yes No

Do you use alcohol? Yes No

If you use drugs or alcohol, what do you use and how often? _____

For women: Are you pregnant? Yes No Maybe

Have you had any diagnostic tests done? Where? When?

- X-rays _____
- Mammogram _____
- MRI _____
- EMG _____
- CT scan _____
- Ultrasound _____
- EKG/Stress test _____
- Other _____

**AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION**

MEDICAL HISTORY:

Do you previously/currently have any of the following medical problems? (please circle or add)

Constitutional: Recent unexpected weight loss, change in appetite, problems sleeping, fever, other.

Details: _____

Eyes: Dry eyes, glasses, contacts, vision changes, other.

Details: _____

Ears, Nose, Mouth, Throat: hearing aids, seasonal allergies, nosebleeds, difficulty breathing, previous injury, other.

Details: _____

Cardiovascular: high blood pressure, heart murmur (antibiotics prior to dental procedure), heart attack, irregular heart beat, mitral valve prolapse, other.

Details: _____

Respiratory: pneumonia, asthma, smoking, other.

Details: _____

Gastrointestinal, Pancreas, Liver: ulcers, bleeding, chronic diarrhea, abdominal pain, pancreatitis, hepatitis, liver disease, other.

Details: _____

Muskuloskeletal: carpal tunnel, joint replacement, muscle problems, broken bones, gout, other.

Details: _____

Renal: kidney problems, urine problems (urinary tract infections), bladder problems, other.

Details: _____

Skin/Breast: skin rash or problems, acne, accutane use, bronzing solution use, breast cancer/surgery, breast lumps, breast biopsies, breast radiation, lymphnode biopsy, other.

Details: _____

Neurological: seizure, head injury, stroke, neuropathy, nerve disease, headaches, migraines, fainting, other.

Details: _____

Endocrine: thyroid, diabetes, hormonal problems, other

Details: _____

Hematologic/Lymphatic: anemia, bleeding tendencies, bruise easily, coumadin use, DVT (deep venous thrombosis) or PE (pulmonary embolism), blood clots, phlebitis, blood disorder, other.

Details: _____

Allergic/Immunologic: anaphylactic reactions, HIV/AIDs, TB(tuberculosis), prolonged or persistent infections, other.

Details: _____

Other: fibromyalgia, depression, anxiety, stress, psychiatric problems, cancer, other.

Details: _____

None of the Above