ERNEST B. ROBINSON, M.D., PC
A PROFESSIONAL CORPORATION

HISTORICAL DATA SHEET

PATIENT NAME:________________________ Age:______ Height:_____Weight:_____
Reason(s) for seeing physician:____

____

Which surgical procedure are you interested in?

___ Rhinoplasty (nose)
___ Eyelids
___ Chin
___ Protruding ears
___ Forehead lift
___ Face or neck lift
___ Scar revision
___ Skin resurfacing
___ Skin cancer
___ Collagen/Botox
___ Other: ____________________
___ Removal of cysts, moles, etc.
___ Lip Augmentation
___ Microdermabrasion

Have you consulted another doctor in regards to this type of surgical procedure? ❑ **Yes** ❑ **No**
If so, whom?____

Please list ***all*** **medications, vitamins, or supplements** you are currently taking (Including birth control pills or other hormones):____
Drug allergies? If so, please list:____

____

PREVIOUS SURGERIES (INCLUDING cosmetic):____________________________________

____

Were there any complications to any of the above mentioned procedures? If so, please describe:________

____

PERSONAL PHYSICIANS

Family doctor / Internist?__________________________ Address:__________________
OB / Gyn?__________________________________ Address:__________________
When was your last physical examination?______________________
May we notify him / her of your visit or upcoming surgery? Yes No
Have you ever or are you currently being treated by a psychiatrist or psychologist? If so, please provide:
Name:____ Phone:____________________

Please circle the appropriate responses for the following "Yes" / "No" questions in this section

Yes **No** Have you ever had any reaction to local or general anesthesia? If so, please describe:

____

Yes **No** Ever taken Accutane? If stopped, when?______ **Yes** **No** Use Nicorette / nicotine patches?
Yes **No** Take aspirin regularly? Tobacco use/amount?__________ If stopped, when_________
Caffeinated drinks / **# per day**_________ Alcohol use/amount?________________ per___________

Are you currently or have you ever been treated or diagnosed for any of the following? (Please mark all that apply).

___ Heart condition
___ Heart murmur
___ Angina
___ Heart Attack
___ Rheumatic heart
___ Congenital heart
___ High blood pressure
___ Stroke
___ Headaches/Migraines
___ Cold sores/Fever blisters
___ Kidney disease
___ Hepatitis/Jaundice
Type: ❑ A ❑ B ❑ C

___ Asthma
___ Hay fever/Nasal allergies
___ Lung/Chest problems: ____________
___ Thyroid disorder/Goiter
___ Hernia
___ Ulcers
___ Arthritis
___ Lupus/Scleroderma
___ HIV/(**AIDS**)
___ Cancer: ❑ Skin
❑ Other, which type:________
____

___ Gall bladder disorders
___ Fibrocystic disease
___ Depression
___ Nervous Breakdown
___ Psychiatric or "nerve" problems
___ Seizures/Convulsions
___ Anemia
___ Bleeding tendencies
___ Easy bruising
___ Diabetes
___ Poor healing
___ Excessive scarring
___ Staph infections

___ Vision changes
___ Any eye problems
___ Skin condition, infection, irritation, or rashes
___ Latex allergy
___ Alcohol/Drug dependency
___ Recreational drugs:
Please list:____________
___ Paralysis/Numbness
___ Bell's Palsy
___ Other:
____
____