

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?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Rhinoplasty (nose) | <input type="checkbox"/> Forehead lift | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Removal of cysts, moles, etc. |
| <input type="checkbox"/> Eyelids | <input type="checkbox"/> Face or neck lift | <input type="checkbox"/> Collagen/Botox | <input type="checkbox"/> Lip Augmentation |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Scar revision | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Protruding ears | <input type="checkbox"/> Skin resurfacing | | |

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).

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall bladder disorders | <input type="checkbox"/> Vision changes |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hay fever/Nasal allergies | <input type="checkbox"/> Fibrocystic disease | <input type="checkbox"/> Any eye problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Lung/Chest problems: | <input type="checkbox"/> Depression | <input type="checkbox"/> Skin condition, infection, irritation, or rashes |
| <input type="checkbox"/> Heart Attack | _____ | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> Rheumatic heart | <input type="checkbox"/> Thyroid disorder/Goiter | <input type="checkbox"/> Psychiatric or "nerve" problems | <input type="checkbox"/> Alcohol/Drug dependency |
| <input type="checkbox"/> Congenital heart | <input type="checkbox"/> Hernia | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Recreational drugs: |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anemia | Please list: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Paralysis/Numbness |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Lupus/Scleroderma | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Bell's Palsy |
| <input type="checkbox"/> Cold sores/Fever blisters | <input type="checkbox"/> HIV/(AIDS) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cancer: <input type="checkbox"/> Skin | <input type="checkbox"/> Poor healing | |
| <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Other, which type: _____ | <input type="checkbox"/> Excessive scarring | |
| Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | _____ | <input type="checkbox"/> Staph infections | |