

Roberts Cosmetic Surgery Center

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Richardson, TX 75080
972-608-0000

COSMETIC PATIENT HEALTH HISTORY

First Name: _____ Last Name: _____ Date: _____

Address: _____ Date of Birth: _____ Age: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____

How do you preferred to be contacted: Cell Phone / Home Phone / Work Phone / Email (circle all that apply)

SSN: _____ Marital Status: Married: _____ Single: _____ Divorced: _____ Widow: _____

REFERRED BY: _____

Emergency Contact: _____

Emergency Contact Phone: _____ Relationship: _____

Family Physician: _____ Phone: _____ City/State: _____

Employer: _____ Occupation: _____

Medical History:

Do we have permission to obtain additional health information from your family physician? Yes No

Do you have any allergies or sensitivities? Yes No If so, please list: _____

Are you currently taking any medications? Yes No If so, please list: _____

Are you currently taking aspirin, ibuprofen, herbs, nutritional supplements, birth control pills or sexual performance drugs? Yes No

If yes, please list: _____

Have you had previous cosmetic, plastic or reconstructive surgery? Yes No

What type of surgery? _____

By Whom? _____

Were there aspects of your surgery that did not meet your expectations? Yes No

If so, please specify: _____

Have you had other types of surgery? Yes No

Type of surgery _____ Date: _____

Type of surgery _____ Date: _____

Type of surgery _____ Date: _____

Did you experience any complications? Yes No

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COSMETIC PATIENT HEALTH HISTORY (cont)

If yes, please specify: _____

Have you ever had local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor? Yes No

Have you ever experienced an adverse reaction to anesthesia? Yes No

If yes, please describe your reaction _____

When was your last physical examination? _____ Do you have a history of bleeding? Yes No

If yes, please specify: _____

Please explain and list any other bleeding problems: _____

PLEASE CIRCLE ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST (CONT.ON NEXT PAGE...)

Allergies	Yes	No	Lung Disease	Yes	No
Hay Fever	Yes	No	Kidney Disease	Yes	No
Nasal Allergies	Yes	No	Bladder Disease	Yes	No
Asthma	Yes	No	Arthritis	Yes	No
Vision/Eye Problems	Yes	No	Decreased circulation (fingers/toes)	Yes	No
Heart Disease	Yes	No	Liver Disease	Yes	No
Chest Pains	Yes	No	Diabetes	Yes	No
High/Low Blood Pressure	Yes	No	Skin Irritations	Yes	No
HIV	Yes	No	Skin Rashes	Yes	No
Stomach Ulcers	Yes	No	Skin Cancer	Yes	No

Have you ever been under the care of a psychologist or psychiatrist? Yes No

If yes, please explain: _____

ETHNICITY: This information is very important for your aesthetician to serve you correctly, and insure the best possible results for your skin treatment.

Please circle one: Anglo-Saxon (Caucasian) / Hispanic / Asian / African American / Middle Eastern / Other (please specify) _____

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome? Yes No

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed? Yes No

Appointment: In effort to stay on schedule, please arrive a few minutes prior to your appointment. Being on time for your appointment assures you will receive your full service and our other clients are not inconvenienced. We reserve the right to reschedule your appointment if you are late. Please schedule your next appointment before you leave.

Cancellations: We require at least 24 hours notice for appointment rescheduling and cancellations. A fee is charged for appointments not cancelled or rescheduled without advance notice. Please see cancellation policy for details and charges.

Policy: Products may not be returned for refunds or credit applied to services, we will not exchange products. Series must be paid for in full prior to service to obtain series pricing and are non-refundable under any circumstances.

Insurance: Our services are cosmetic and cosmetic services are not covered by insurance plans.

 Patient or Responsible Party Signature Date: _____

 Physician's Signature Date: _____