Roberts Cosmetic Surgery Center
Gregory D. Roberts, MD
5144 Village Creek Drive
Plano, TX 75093
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: _____

For patient confidentiality, Roberts' staff typically will contact you via cell phone or text or email, prior to calling work or home. If you do not wish us to contact you via any of the above, please tell us: _____

SSN:_____ Marital Status: Married:_____Single:_____Divorced:_____Widow:_____

Occupation:_____ Employer: _____

WHOM MAY WE THANK FOR REFERRING YOU:_____

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

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

Emergency Contact: _____

Emergency Contact Phone:_____ Relationship_____

Medical History:

Do you have any medication 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 ____

If yes, please specify: _____

_____

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COSMETIC PATIENT HEALTH HISTORY (cont.)

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 ____ When was your last physical examination?_____

If yes, please describe your reaction _____

_____

Do you have a history of bleeding? Yes ____ No ____ If yes, please specify:_____

_____

[Female Only] Are you pregnant or breastfeeding: _____

_____

PLEASE CIRCLE ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST

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
Thyroid Disease	Yes	No	Gastro Esophageal Reflux	Yes	No
Heart Disease	Yes	No	Liver Disease/Hepatitis	Yes	No
Chest Pains	Yes	No	Diabetes	Yes	No
High/Low Blood Pressure	Yes	No	Skin Irritations	Yes	No
HIV or AIDS	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: 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, as well as 14 day advance email or text notice of cancellation of a Slimlipo or surgical procedure, and a 7 day advance email or text notice of any other procedure cancelation. A fee is charged for appointments not cancelled or rescheduled without advance notice per the refund policy. Please see Roberts Cosmetic Surgery refund policy for details and charges.

Product Returns: Products may not be returned for refunds or credit applied to services. Roberts Cosmetic Surgery will not exchange products.

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

_____Date:_____

Patient or Responsible Party Signature

_____Date:_____

Physician's Signature