

**Robert M. Schwarcz, M.D., F.A.C.S.**

**PATIENT HISTORY**

**PLEASE PRINT and COMPLETE ALL INFORMATION**

**Appointment Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Sex:**  M  F  
First Middle Last

**Address:** \_\_\_\_\_  
Street # & Name City State Zip Code

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**S.S. #** \_\_\_\_\_ **S**  **M**  **D**  **W**  **Spouse Name:** \_\_\_\_\_  
Marital Status

**Your Telephone:** Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**\*\* May we call you at work?  Y  N**

**Your Occupation:** \_\_\_\_\_ **Your Employer:** \_\_\_\_\_

**Your Employer Address:** \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

Family Physician: _____ Phone: _____ Fax: _____ First Last
Address of Family Physician: _____ Street # & Name City State Zip
Referring Physician: _____ Phone: _____ Fax: _____ (if other than family physician) First Last
Address of Referring Physician: _____ Street # & Name City State Zip

- 1. Please list your reasons for this consultation:** \_\_\_\_\_  
\_\_\_\_\_
2. Have you had previous cosmetic surgery?  YES  NO If yes, please list procedure(s): \_\_\_\_\_  
\_\_\_\_\_
3. Were there any complications?  YES  NO If yes, please list complications: \_\_\_\_\_  
\_\_\_\_\_
4. Do you have a history of eye problems, dry eyes, or eye surgery?  YES  NO
5. Do you wear glasses?  YES  NO Contact Lenses?  YES  NO
6. Any history of radiation treatment to the face?  YES  NO
7. Have you, or do you currently use Retin-A or glycolic acids for skin care?  YES  NO
8. Have you ever received a chemical peel, dermabrasion, or laser resurfacing?  YES  NO
9. Were there any complications?  YES  NO  
If yes, please list: \_\_\_\_\_

10. Any history of skin cancer?  YES  NO If yes, what area? \_\_\_\_\_

11. Any history of hypertrophic (keloid) scar anywhere on your body?  YES  NO

12. Have you ever taken Accutane for acne treatment?  YES  NO If yes, date last taken: \_\_\_\_\_

13. Have you ever consulted or been treated by a psychiatrist or psychologist?  YES  NO  
If yes, please explain circumstances: \_\_\_\_\_

14. Are you, or might you possibly be pregnant?  YES  NO  NOT APPLICABLE

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### MEDICAL HISTORY

#### List all medication allergies

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

#### List all medications you are presently taking including strength and how often

- |       |    |                            |       |       |    |                            |       |
|-------|----|----------------------------|-------|-------|----|----------------------------|-------|
| _____ | mg | <input type="checkbox"/> X | a Day | _____ | mg | <input type="checkbox"/> X | a Day |
| _____ | mg | <input type="checkbox"/> X | a Day | _____ | mg | <input type="checkbox"/> X | a Day |
| _____ | mg | <input type="checkbox"/> X | a Day | _____ | mg | <input type="checkbox"/> X | a Day |
| _____ | mg | <input type="checkbox"/> X | a Day | _____ | mg | <input type="checkbox"/> X | a Day |
| _____ | mg | <input type="checkbox"/> X | a Day | _____ | mg | <input type="checkbox"/> X | a Day |

**ARE YOU ALLERGIC TO LATEX?**  YES  NO

Please list **ALL** vitamins, supplements, and/or herbs you are presently taking. \_\_\_\_\_

Are you currently under treatment for alcohol or drug abuse?  YES  NO

How much alcohol do you consume in one week?  None  Light  Moderate  Heavy

Do you presently smoke?  YES  NO If yes, amount per day \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever smoked?  YES  NO If yes, amount per day \_\_\_\_\_ How long? \_\_\_\_\_

List below all hospitalizations for illness, surgery, accident or fracture:

Year: \_\_\_\_\_ Hospital: \_\_\_\_\_ Reason: \_\_\_\_\_

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Year: \_\_\_\_\_ Hospital: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Hospital: \_\_\_\_\_ Reason: \_\_\_\_\_

Have you ever had Tuberculosis (TB)?  YES  NO

Have you ever been exposed to Tuberculosis (TB) within the past year?  YES  NO

Have you ever had or been treated for any of the following: (Please check if **Yes**)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> allergy/hay fever         | <input type="checkbox"/> asthma/wheezing                    | <input type="checkbox"/> pneumonia                            | <input type="checkbox"/> palpitation or pounding chest    |
| <input type="checkbox"/> anemia                    | <input type="checkbox"/> bone or joint deformity            | <input type="checkbox"/> tightness in chest                   | <input type="checkbox"/> recent gain or loss of weight    |
| <input type="checkbox"/> back problems/pain        | <input type="checkbox"/> broken bones or bone disease       | <input type="checkbox"/> excessive worry or depression        | <input type="checkbox"/> rheumatic fever                  |
| <input type="checkbox"/> cancer                    | <input type="checkbox"/> shortness of breath                | <input type="checkbox"/> frequent or severe indigestion       | <input type="checkbox"/> cataract/glaucoma                |
| <input type="checkbox"/> diabetes                  | <input type="checkbox"/> cancer, cyst, growth or tumor      | <input type="checkbox"/> frequent or severe headaches         | <input type="checkbox"/> sugar or albumin in urine        |
| <input type="checkbox"/> epilepsy/seizure disorder | <input type="checkbox"/> chronic cough/recent cold          | <input type="checkbox"/> kidney stone or blood in urine       | <input type="checkbox"/> scarlet fever                    |
| <input type="checkbox"/> eye injury/disease        | <input type="checkbox"/> chest pain or pressure             | <input type="checkbox"/> liver disease or jaundice            | <input type="checkbox"/> severe ear, nose, throat trouble |
| <input type="checkbox"/> fainting spells           | <input type="checkbox"/> coughing or vomiting blood         | <input type="checkbox"/> loss of appetite, nausea or vomiting | <input type="checkbox"/> swelling of ankles or feet       |
| <input type="checkbox"/> frequent colds            | <input type="checkbox"/> change in bowel habits or bleeding | <input type="checkbox"/> neuritis (inflammation of nerve)     | <input type="checkbox"/> swollen or painful joints        |
| <input type="checkbox"/> head injury               | <input type="checkbox"/> chills, fever, night sweats        | <input type="checkbox"/> pain in shoulder, arms or hands      | <input type="checkbox"/> tuberculosis                     |
| <input type="checkbox"/> heart trouble/pace maker  | <input type="checkbox"/> dizziness or passing out spells    | <input type="checkbox"/> tendonitis weak wrists               | <input type="checkbox"/> bladder infection                |
| <input type="checkbox"/> high blood pressure       | <input type="checkbox"/> double vision or blindness         | <input type="checkbox"/> repeated diarrhea                    | <input type="checkbox"/> thyroid trouble                  |
| <input type="checkbox"/> nervousness               | <input type="checkbox"/> difficult in sleeping              | <input type="checkbox"/> constipation                         | <input type="checkbox"/> heart murmur                     |
| <input type="checkbox"/> lung trouble              | <input type="checkbox"/> ringing in ears                    | <input type="checkbox"/> frequent urination                   | <input type="checkbox"/> gout                             |
| <input type="checkbox"/> peptic/stomach ulcers     | <input type="checkbox"/> excess tiredness/fatigue           | <input type="checkbox"/> hepatitis                            | <input type="checkbox"/> phlebitis of vein                |
| <input type="checkbox"/> arthritis                 | <input type="checkbox"/> weakness in a limb                 | <input type="checkbox"/> AIDS or ARC                          | <input type="checkbox"/> trouble concentrating            |
| <input type="checkbox"/> sinus trouble             | <input type="checkbox"/> numbness in a limb                 | <input type="checkbox"/> stroke                               | <input type="checkbox"/> heart attack, heart valve        |
| <input type="checkbox"/> skin rash/disease         | <input type="checkbox"/> emphysema                          | <input type="checkbox"/> infections                           | <input type="checkbox"/> congestive heart failure         |
| <input type="checkbox"/> bleeding disorder         | <input type="checkbox"/> prolonged hoarseness               | <input type="checkbox"/> burning urination                    | <input type="checkbox"/> Mitral Valve Prolapse            |