South Walton Plastic Surgery
2048 W. Co Hwy 30A
Santa Rosa Beach, FL 32459
Office number: 850-387-2398
Fax number: 850-806-1879

Patient Information

Name (last, first middle): _____ **Date of Birth:** _____

Social Security Number: _____

Address: _____ **City, State, Zip:** _____

Contact Number: _____ **Email Address:** _____

Parent or Spouse Name: _____ **Contact Number:** _____

Primary Care Physician Name and Contact info _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Phone Number: _____

Cosmetic Consultation: Circle the areas of interests

Breast: Explantation (Removal of implants with Capsulectomies), Mastopexy (Lift), Reduction, Fat Grafting
Body: Abdominoplasty (Tummy Tuck), Liposuction
Face: Upper Blepharoplasty (eyelid)
Brachioplasty (arms)
Injectables: Filler, Botox

How did you hear about us: _____

Preferred Pharmacy: _____ **Phone Number:** _____

Communication Use & Disclosure Authorization:
You may leave a voicemail, text and/or send an email regarding:
____Appointment Information ____ Prescription/refill info ____Referral information ____
____Test results _____Other

You may discuss information and care with the following family member(s) or persons:
_____

If the number is different than above, please contact me regarding my treatment and care at the following number:
_____

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Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Adrenal Insufficiency
- ☐ Anemia/Thalassemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Auto-Immune Disease
- ☐ Back Pain
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Head Trauma
- ☐ Hernia
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Other _____
- ☐ HIV / AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lupus
- ☐ Malignant Hypertension
- ☐ Neuromuscular Disorder
- ☐ Paralysis
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Renal Disorder
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Severe Reaction to Anesthesia
- ☐ Stroke
- ☐ Trauma
- ☐ Valvular Heart Disease
- ☐ Vision Loss
- ☐ None

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Past Surgeries

List all other prior surgeries here (not including plastic surgery) and the dates of surgery?

Plastic Surgery History (include surgery date and surgeon)

- ☐ Abdomen: Abdominal Wall Reconstruction
- ☐ Abdomen: Abdominoplasty
- ☐ Body Contouring: Brachioplasty
- ☐ Body Contouring: Liposuction
- ☐ Body Contouring: Lower Body Lift
- ☐ Body Contouring: Thigh Lift
- ☐ Body Contouring: Upper Body Lift
- ☐ Breast: Breast Augmentation
- ☐ Breast: Breast Lift (Mastopexy)
- ☐ Breast: Breast Reconstruction
- ☐ Breast: Breast Reduction
- ☐ Breast: Correction of Nipple Inversion
- ☐ Breast: Implant Removal
- ☐ Breast: Nipple Reconstruction
- ☐ Chemical Peel
- ☐ Cubital Tunnel Release
- ☐ Ears: Ear Reconstruction
- ☐ Ears: Earlobe Repair
- ☐ Ears: Otoplasty
- ☐ Face: Blepharoplasty
- ☐ Face: Brow Lift
- ☐ Face: Cheek Augmentation
- ☐ Face: Chin Augmentation
- ☐ Face: Facelift
- ☐ Face: Facial Fracture Repair
- ☐ Face: Facial Reanimation
- ☐ Face: Frontal Sinus Fracture
- ☐ Face: Lower Blepharoplasty
- ☐ Face: Upper Blepharoplasty
- ☐ Fat Grafting
- ☐ Hair Restoration
- ☐ Laser Hair Removal
- ☐ Laser Resurfacing
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Scar Revision
- ☐ Other _____

Include date of plastic surgery if procedure is checked above and implant size and include copy of implant card if possible with new patient forms

Gynecologic History

LAST MAMMOGRAM
MM/DD/YYYY _____

Obstetric History

Number of pregnancies:
Number of births: _____Method of delivery: _____Vaginal _____C-Section
Have you had any miscarriages?

Breast Cancer

Do you have a family history of breast cancer?

◯ Yes ◯ No

If so, which relative

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Niece
- ☐ Grandfather
- ☐ Granddaughter
- ☐ Other _____
- ☐ None
- ☐ Nephew
- ☐ Grandmother
- ☐ Grandson

Blood Clots

Do you have a history of blood clots?

◯ Yes ◯ No

Do you have a FAMILY history of blood clots?

◯ Yes ◯ No

Malignant Hyperthermia and Anesthesia Sensitivity

Do you have a family history of severe reactions to anesthesia?

◯ Yes ◯ No If yes, what type of reaction? _____

If so, which relative

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

Herbal Medications and Supplements

Do you take any herbal medications or supplements?

◯ Yes ◯ No

Please list herbal medication and supplements:

Medications

List all current medications and dosage:

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

Social History

Smoking Status (please choose one)

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker current status unknown
- ☐ Unknown if ever smoked

Start Smoking

MM/DD/YYYY _____

Quit Smoking

MM/DD/YYYY _____

☐ Number of Packs Per Day: