



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: _____

Gender: _____ Social Security Number: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Cell Phone: _____

Parent or Spouse Information Name: _____

Contact Number: _____

Primary Care Physician Name: _____ Number: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

Preferred Pharmacy: _____ Phone Number: _____

Communication Use & Disclosure Authorization:

You may leave a voicemail 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:



Past Medical History

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

Select any of the following medical conditions you currently have:

South Walton Plastic Surgery

Past Surgeries

List all surgeries and the dates of surgery?

Plastic Surgery History

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

Gynecologic History

LAST MAMMOGRAM

MM/DD/YYYY _____

Obstetric History

Number of pregnancies: _____

Number of births: _____

Method of delivery:

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

Other _____

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)

- | | |
|--|---|
| <input type="checkbox"/> Current everyday smoker | <input type="checkbox"/> Current someday smoker |
| <input type="checkbox"/> Former smoker | <input type="checkbox"/> Never smoker |
| <input type="checkbox"/> Smoker current status unknown | <input type="checkbox"/> Unknown if ever smoked |

Start Smoking

MM/DD/YYYY _____

Quit Smoking

MM/DD/YYYY _____

Number of Packs Per Day: