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 Information 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 (Aug, Implant Exchange, Explant, Lift, Reduction, Fat Grafting)
Body (Tummy Tuck, Liposuction, Arms, Thighs)
Face (Facelift, Facial Fat Grafting)
Injectables, etc
Renuvion: Face, Arms, Abdomen

How did you hear about us: _____

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:
_____

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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 surgeries and the dates of surgery?

Plastic Surgery History

- ☐ 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 _____

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)

☐ 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: