FORREST P. WALL, M.D.

Patient Name ______________________ Date of Birth ____________ Age ____________

Address ______________________ City ______________ State _____ Zip__________

Home # ____________ Cell # ____________ Email Address ______________________

Social Security Number ______________ Patient's Employer ______________________

Address ______________ City ______________ State______ Zip______ Work # ____________

Gender: ○ Male ○ Female **Martial Status:** ○Minor ○Single ○Married ○Divorced ○Widowed ○Separated

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name ______________________ Relationship ____________ Phone # ____________

RESPONSIBLE PARTY

Person responsible for this account ______________ Relationship to patient ____________

Address ______________________ City ______________ State _____ Zip__________

Phone # ____________ Date of Birth ____________ Social Security Number ____________

Employer ______________________ Address ______________________

City ______________ State__________ Zip__________ Work # ______________

Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis. (Including treatment, payment and health care options).

Name: ______________________ **Relationship:** ______________

Name: ______________________ **Relationship:** ______________

Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address. ______________________

Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**

○ Yes ○ No

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, and other health care information if other than your home telephone number. ______________

Can confidential messages be left on your telephone answering machine? ○Yes ○No

INSURANCE INFORMATION

Primary Insurance ______________ Policy # ______________ Group # ____________

Claims Address ______________________ Phone # ____________

Policy Holder Name ______________ DOB ____________ SSN ______________

Relationship of Insured to Patient: ○ Self ○ Spouse ○ Parent/Guardian

Secondary Insurance ______________ Policy # ______________ Group # ____________

Claims Address ______________________ Phone # ____________

Policy Holder Name ______________ DOB ____________ SSN ______________

Relationship of Insured to Patient: ○ Self ○ Spouse ○ Parent/Guardian

Patient/Guarantor Signature ______________________ **Date**__________

FORREST P. WALL, M.D.

PATIENT PERSONAL MEDICAL HISTORY

Reason for today's visit:

Other Procedures I would be interested in discussing in future visits:

- ☐ Abdominal Lipectomy (Tummy Tuck)
- ☐ Rhytidectomy (Face Lift)
- ☐ Breast Reduction
- ☐ Post-Mastectomy Reconstruction
- ☐ Laser Skin Resurfacing
- ☐ Breast Augmentation (Breast Implants)
- ☐ Rhinoplasty (Nose Contouring)
- ☐ Liposuction
- ☐ Mastopexy (Breast Lift)
- ☐ Blepharoplasty (Eyelids)
- ☐ Skin Care
- ☐ Botox/Restylane Injections
- ☐ Chemical Peels
- ☐ Other Plastic Surgery

How did you hear about us?

- ☐ Phone Book
- ☐ Television
- ☐ Internet
- ☐ Seminar
- ☐ Physician Referral
- ☐ Friend/Family

Whom can we thank: ______________________

- ☐ Facebook/Twitter

Other: ______________________

Do you have a Living Will? ○ Yes ○ No

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE PHOTOGRAPHS TAKEN TO BE USED FOR MEDICAL, SCIENTIFIC, OR EDUCATIONAL PURPOSES, PROVIDED THE PICTURES DO NOT REVEAL MY IDENTITY.

______________________________ ______________________

Signature of Patient/Parent if a Minor Date

____

Name (Please Print)

FORREST P. WALL, M.D.

PATIENT PERSONAL MEDICAL HISTORY

Full Name: ______________________ Date of Birth: ______________

Please answer all of the questions as accurately as possible. This is a confidential record of your medical history and will be kept in the office. If you do not understand the question, please ask for assistance.

Family Doctor or Internist: ______________________ Date of Last Exam: ________

Height: _______ Weight: ________

Do you Smoke? ___ Yes ___ No Type & Amount Per Day: ______________

How Long? ______________ If Former Smoker, Date Quit: ________

Do you use:

Alcohol ___ Yes ___ No Type & Amount Per Week ______________

Caffeine ___ Yes ___ No Type & Amount Per Week ______________

Street Drugs ___ Yes ___ No Type & Amount Per Day ______________

Drug Allergies: ______________________________

Other Allergies: ☐Iodine ☐Shellfish ☐Tape ☐Band-Aids ☐Latex Other ______________

Please list any medications you are currently taking:

PRESCRIPTION	NON-PRESCRIPTION	VITAMINS,HERBALS,ETC.

Please list all Hospitalizations, Serious Illnesses, Surgeries and the Date they occurred:

Please describe all Serious Accidents, Severe Injuries, Broken Bones, or Head Injuries and the Date they occurred:

Women: Date of Last Menstrual Period: ____________ Are you Pregnant? ___ Yes ___ No
Total Number of Pregnancies: ____________ Number of Children: ________
Did you Breast feed? ___ Yes ___ No Date of Last Mammogram: ________

Forrest P. Wall, M.D.

PATIENT PERSONAL MEDICAL HISTORY

PAST MEDICAL HISTORY: Have you ever had the following:

- ☐ Heart Disease
- ☐ Anemia
- ☐ Cancer:
- ☐ AIDS or HIV
- ☐ Ulcer: Cold Sores
- ☐ Kidney Disease
- ☐ Bleeding Tendency
- ☐ Mitral Valve Prolapse
- ☐ Measles
- ☐ Shingles
- ☐ Whooping Cough
- ☐ Venereal Disease
- ☐ Transfusion
- ☐ Low Blood Pressure
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Glaucoma
- ☐ Stroke
- ☐ Fever Blisters
- ☐ Thyroid Disease
- ☐ Epilepsy
- ☐ Back Trouble
- ☐ Mumps
- ☐ Genital Herpes
- ☐ Scarlet Fever
- ☐ Polio
- ☐ Hemorrhoids
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Asthma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Chickenpox
- ☐ Migraine Headaches
- ☐ Diphtheria
- ☐ Hernia
- ☐ Hives
- ☐ Mononucleosis
- ☐ High Cholesterol
- ☐ Eczema
- ☐ Bronchitis

Any Other Diseases, please list:

Date of last Chest X-Ray: ______________________ Date of last Tetanus Shot: ______________

REVIEW OF SYSTEMS: Do you have now or have you had within the past year:

- ☐ Weight Change
- ☐ Dry Eyes
- ☐ Chronic Cough
- ☐ Chest Pain
- ☐ Rapid Heart Beat
- ☐ Breast Pain
- ☐ Swollen Feet/Ankles
- ☐ Skin Rash
- ☐ Chronic Diarrhea
- ☐ Jaundice
- ☐ Depression
- ☐ Breast Lump or Mass
- ☐ Seizures
- ☐ Joint/Muscle Pain
- ☐ Swollen Lymph Nodes
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Breast Discharge

FAMILY HISTORY:

Present age, or age at death		State of Health (good, fair, poor) or cause of death
Mother	______________	______________
Father	______________	______________
Brother (s)	______________	______________
Sister (s)	______________	______________
Children	______________	______________

HAS ANY RELATIVE HAD ANY OF THE FOLLOWING:

- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Bleeding Tendency
- ☐ Drug Alcohol Problem
- ☐ Migraine Headaches
- ☐ Ulcer
- ☐ Glaucoma
- ☐ Stroke
- ☐ Diabetes
- ☐ Anemia
- ☐ Asthma
- ☐ Mental Illness
- ☐ Obesity
- ☐ Depression
- ☐ Gout
- ☐ Tuberculosis
- ☐ Allergies
- ☐ High Blood Pressure
- ☐ Chronic Lung Disease
- ☐ Leukemia
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ Kidney Disease