

ARIC J. ECKHARDT, M.D.

600 John Deere Rd., Ste. 401

Moline, IL. 61265

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please print Name

Signature

Date

For Office Use Only

attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- () Individual refused to sign
- () Communication barriers prohibited obtaining the acknowledgement
- () An emergency situation prevented us from obtaining acknowledgement
- () Other (Please Specify)

ALL HEALTH QUESTIONS MUST BE ANSWERED!!

Please describe your complaint or why you are here: _____

Past Medical History:

Height _____ Weight _____ Any weight loss? _____ How much? _____

PREVIOUS SURGERY (Please list)

Operation	Year	Complications

SERIOUS INJURIES (Please list)

Type	Year	After Effects

MEDICATIONS, DRUGS

Please list ALL medications you are now taking (including birth control pills, diuretics/water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, ibuprofen, etc.

GENERAL HISTORY

Have you ever been pregnant? Yes _____ No _____ If yes, how many times? _____
How many children do you have? _____ Are you now pregnant? _____

Are you allergic to any pills, drugs or medications?	Yes _____ No _____	If yes, please comment _____ _____ _____
Do you have any other known allergies?	Yes _____ No _____	
Have you ever had a bad reaction to a general anesthesia?	Yes _____ No _____	
Have you ever had a bad reaction to a local Anesthesia	Yes _____ No _____	

Do you have high blood pressure?	Yes_____	No_____	_____
Do you bleed unusually easily? (from cuts, surgery)?	Yes_____	No_____	_____
Do you form large scars or keloids?	Yes_____	No_____	_____
Do you have frequent infections or boils?	Yes_____	No_____	_____
Have you ever had any significant emotional problem?	Yes_____	No_____	_____
Have you ever had psychiatric care?	Yes_____	No_____	_____
Have you ever been advised to see a psychiatrist?	Yes_____	No_____	_____
Have you seen other plastic surgeons about the SAME problem which brings you here?	Yes_____	No_____	_____

I consent to the taking and publication of any photographs in the course of any evaluation/consultation/surgical procedure for the advancing of medical education. I realize that my identity may be revealed by such photographs or by the descriptive text accompanying them.

Date

Signature of Patient or Guardian