PATIENT REGISTRATION				
TODAY'S DATE	EKQ PLASTIC SUR aesthetic. reconstructive			
Patient Information				
LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	
STREET ADDRESS				
СІТУ			STATE	ZIP
HOME PHONE WORK	PHONE	CELL		
EMAIL			SOCIAL SECURITY NU	MBER
MAY WE EMAIL EVENT SPECIALS & NEWSLETTER	s to you? 🛛 Yes 🗆 No			
REFERRING PHYSICIAN	PRIM/	ARY CARE PHYSICIAN		
PHARMACY				
How did you hear about Dr. Eko?				

# Insurance Information

EMPLOYER	OCCUPATI	ON
ADDRESS		MARITAL STATUS
PRIMARY INSURANCE C	COMPANY	POLICY NUMBER
	NAME OF PERSON INSURED	
GROUP NUMBER	NAME OF PERSON INSURED	SOCIAL SECURITY NUMBER
ELIGIBILITY PHONE NU	MBER	COPAY
ELIGIBILITY PHONE NU		COPAY POLICY NUMBER
SECONDARY INSURANC	CE COMPANY	POLICY NUMBER
SECONDARY INSURANC		
SECONDARY INSURANC	NAME OF PERSON INSURED	POLICY NUMBER SOCIAL SECURITY NUMBER
SECONDARY INSURANC	NAME OF PERSON INSURED	POLICY NUMBER
SECONDARY INSURANC	NAME OF PERSON INSURED	POLICY NUMBER SOCIAL SECURITY NUMBER
SECONDARY INSURANC	NAME OF PERSON INSURED	POLICY NUMBER SOCIAL SECURITY NUMBER



What is the reason for your visit today	y? (Check all applicable procedures below)	
Nose & Face	Breast & Body	MediSpa
Primary Rhinoplasty	□ Breast Augmentation	□ Botox <sup>®</sup>
Revision Rhinoplasty	Breast Augmentation with Breast Lift	□ Restylane <sup>®</sup>
□ Brow Lift	□ Breast Reduction	□ Perlane®
□ Facelift	□ Capsulectomy	□ Juvéderm®
🗆 Neck Lift	Mommy Makeover	□ Radiesse®
□ Eyelid Surgery	□ Abdominoplasty	🗆 Enzyme Peel
Facial Implants	Post-Bariatric Body Lift	🗆 Laser Hair Removal
□ Chin Augmentation	□ Brachioplasty (Arm Tuck)	🗆 Skin Tightening Laser
□ Lip Augmentation	□ Liposuction	🗆 Photo Facial
□ Lip Suspension	□ Other	Pixel Treatment
□ Other	□ Other	Cellulite Treatment
□ Other	□ Other	🗆 Vein Treatment
□ Other	□ Other	Other

Please describe why you are interested in having the procedure(s) listed above:\_\_\_\_\_

Have you consulted with other physicians about procedure(s) indicated above: □ No □ Yes

If Yes, please describe your understanding of the procedure(s)

Is this procedure a revision from a previous surgery □ No □ Yes If yes, how many previous surgeries?\_\_\_\_\_

What is your "ideal time frame" for procedure(s) completion \_\_\_\_\_\_

## **Health Information**

#### **Personal Past History**

Do you have any chronic medical problems? (Check all that apply)

High Blood Pressure	□ Diabetes	□ Cancer		
□ Heart Disease	□ Kidney Disease	$\Box$ HIV or AIDS		
□ Heart Failure	Psychiatric Diagnosis	□ Stroke		
□ Seizures	□ Bleeding Problems	□ Hepatitis		
Heart Attack	□ Liver Disease	🗆 Emphysema		
🗆 Chest Pain	□ Gastric Reflux	Stomach Problems		
□ Asthma	□ Other			
Letter a second of the first of				

Is there a personal or family history of anesthetic complications?  $\Box$  No  $\Box$  Yes

If yes, please explain \_\_\_\_\_

### **Family History**

Do you have a family history of any medical problems? (Check all that apply) Please indicate family member.

□ High Blood Pressure □ Diabetes □ Cancer  $\Box$  HIV or AIDS □ Heart Disease □ Kidney Disease □ Heart Failure □ Psychiatric Diagnosis □ Stroke □ Seizures □ Bleeding Problems □ Hepatitis □ Heart Attack □ Liver Disease □ Emphysema □ Chest Pain □ Gastric Reflux □ Stomach Problems □ Asthma □ Other\_\_\_\_\_



Please list all prior operations	Date	List any complications
t		
2		
3		
4		
5		
6		
Please list all prior Hospitalizations	Date	List any complications
1		
2		
3		
4		
5		

## Medications

Please list ALL MEDICATIONS and/or dietary supplements (PLEASE PROVIDE A LIST IF YOU HAVE ONE) including:

(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1	5
2	6
3	7
4	8

## Allergies

Please list ALL ALLEF	RGIES and describe reactions	: (i.e. Shellfish, Latex, Penic	cillin, etc).	
1. ALLERGY:		REACTION		
2. ALLERGY:		REACTION		
3. ALLERGY:		REACTION		
4. ALLERGY:		REACTION		
5. ALLERGY:		REACTION		
Social History:				
Have you ever used toba	acco products? $\Box$ No $\Box$ Yes	If yes, how long?	How many pack	xs per day?
Which tobacco product(	s) have you used?		_	
If you are a former smoke	ker, state the year you stopped:		_	
Past or current use of N	icotine Gum, Patch, or any other	type of stop-smoking aid	: □No □Yes	
If yes, please list:				
Alcohol Consumption:	□ Never (Do not consume alcohol)	□ Rare (1-2 drinks a week)	□ Moderate (7-10 drinks a week)	☐ Heavy (daily or more than 10 drinks a wk)
Did you ever drink heav	ily in the past?	□ No □ Yes		
Are you feeling hopeless	s about the present/future?	□ No □ Yes		
Do you currently have the	houghts of harming yourself?	□ No □ Yes		



#### **Review of Systems**

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

StrokeStrokeYesNoShortness of Breath on ExertionYesNoSeizuresYesNoCough with SputumYesNoFaintingYesNoCough with SputumYesNoDizzinessYesNoSleep ApneaYesNoHeadacheYesNo- Use a C-PAP MachineYesNoDouble VisionYesNo- Use a C-PAP MachineYesNoDepressionYesNoHerniated discYesNoDepressionYesNoArthritisYesNoAnxietyYesNoArthritisYesNoPsychiatric CareYesNoArthritisYesNoObsessive Compulsive DisorderYesNoNeck, Back, Arm, Leg ProblemsYesNoDiabetesYesNoHepatitisYesNoNoThyroid DiseaseYesNoHepatitisYesNoTaken SteroidsYesNoHepatitisYesNoBleeding TendencyYesNoHeartburnYesNoEasy BruisingYesNoUIRINARY/REPRODUCTIVENoBlood clots in LungsYesNoUIRINARY/REPRODUCTIVENoBlood clots in LungsYesNoHifteniaYesNoBlood clots in LungsYesNoIf female, could you be pregnant?YesNoBlood clots in LungsYesNoIf female, could you be pregnan	CARDIOVASCULAR		SKIN	
Angina/Chest Pain       Yes       No       Staph Infection       Yes       No         Heart Bypass Surgery       Yes       No       RESPIRATORY       Yes       No         Pacemaker       Yes       No       Abnormal Chest X-ray       Yes       No         Heart Failure       Yes       No       Asthma       Yes       No         Heart Murmur       Yes       No       Bronchitis       Yes       No         Do you Exercise?       Yes       No       Recent Chest Infection       Yes       No         Comments:	High Blood Pressure	□ Yes □ No	Basal Cell Skin Cancer	□ Yes □ No
Heart Bypass Surgery       Yes       No       RESPIRATORY         Pacemaker       Yes       No       Abnormal Chest X-ray       Yes       No         Heart Failure       Yes       No       Asthma       Yes       No         Irregular Heartbeat       Yes       No       Bronchitis       Yes       No         Heart Murmur       Yes       No       Emphysema       Yes       No         Do you Exercise?       Yes       No       Recent Chest Infection       Yes       No         Comments:	Heart Attack	□ Yes □ No	Melanoma	□ Yes □ No
Pacemaker       Yes       No       Abnormal Chest X-ray       Yes       No         Heart Failure       Yes       No       Asthma       Yes       No         Irregular Hearbeat       Yes       No       Bronchitis       Yes       No         Do you Exercise?       Yes       No       Bronchitis       Yes       No         Comments:	Angina/Chest Pain	🗆 Yes 🗆 No	Staph Infection	□ Yes □ No
Heart Failure       Yes       No       Asthma       Yes       No         Irregular Heartbeat       Yes       No       Bronchitis       Yes       No         Heart Murmur       Yes       No       Emphysema       Yes       No         Do you Exercise?       Yes       No       Recent Chest Infection       Yes       No         Storke       Yes       No       Shortness of Breath at Night       Yes       No         Stroke       Yes       No       Cough       Yes       No         Stroke       Yes       No       Cough with Sputum       Yes       No         Sitroke       Yes       No       Cough with Sputum       Yes       No         Beadche       Yes       No       Sleep Apnea       Yes       No         Duble Vision       Yes       No       Sleep Apnea       Yes       No         Psychiatric Care       Yes       No       Herniated disc       Yes       No         Duble Vision       Yes       No       Recent Class Charper No       No       Sciatica       Yes       No         Depression       Yes       No       Recent Astrone Recent	Heart Bypass Surgery	🗆 Yes 🗆 No	RESPIRATORY	
Heart Failure       Yes       No       Asthma       Yes       No         Irregular Heartbeat       Yes       No       Bronchitis       Yes       No         Heart Murmur       Yes       No       Emphysema       Yes       No         Do you Exercise?       Yes       No       Recent Chest Infection       Yes       No         NEUROLOGICAL       Shortness of Breath       Yes       No       Shortness of Breath at Night       Yes       No         Stroke       Yes       No       Cough       Shortness of Breath at Night       Yes       No         Stroke       Yes       No       Cough with Sputum       Yes       No         Dizziness       Yes       No       Sleep Apnea       Yes       No         Duble Vision       Yes       No       Sleep Apnea       Yes       No         Depression       Yes       No       MuscuLoSKELETAL       Sciatica       Yes       No         Psychiatric Care       Yes       No       Heataded disc       Yes       No       No         Pospositive Disorder       Yes       No       Recent Chest, Acrm, Leg Problems       Yes       No         Diabetes       Yes       No       Rea	Pacemaker	🗆 Yes 🗆 No	Abnormal Chest X-ray	□ Yes □ No
Heart Murmur       Yes       No       Emphysema       Yes       No         Do you Exercise?       Yes       No       Emphysema       Yes       No         Comments:	Heart Failure	🗆 Yes 🗆 No		□ Yes □ No
Do you Exercise?       Yes       No       Recent Chest Infection       Yes       No         Comments:       Shortness of Breath       Yes       No         NEUROLOGICAL       Shortness of Breath at Night       Yes       No         Stroke       Yes       No       Shortness of Breath on Exertion       Yes       No         Stroke       Yes       No       Cough       Yes       No         Seizures       Yes       No       Cough with Sputum       Yes       No         Dizziness       Yes       No       Cough with Sputum       Yes       No         Headache       Yes       No       Shortness of Breath on Exertion       Yes       No         Double Vision       Yes       No       Cough with Sputum       Yes       No         Double Vision       Yes       No       - Use a C-PAP Machine       Yes       No         Depression       Yes       No       MUSCULOSKELETAL       Sciatica       Yes       No         Obsessive Compulsive Disorder       Yes       No       Recent Athritis       Yes       No         Diabets       Yes       No       Neck, Back, Arm, Leg Problems       Yes       No         HEMATOLOGIC/ONCOLOGIC/			Bronchitis	□ Yes □ No
Comments:		🗆 Yes 🗆 No	Emphysema	🗆 Yes 🗆 No
NEUROLOGICAL       Shortness of Breath at Night       Yes       No         Stroke       Yes       No       Shortness of Breath at Night       Yes       No         Seizures       Yes       No       Cough       Yes       No         Fainting       Yes       No       Cough with Sputum       Yes       No         Dizziness       Yes       No       Sleep Apnea       Yes       No         Headache       Yes       No       -Use a C-PAP Machine       Yes       No         Double Vision       Yes       No       Headache       Yes       No         Depression       Yes       No       Herniated disc       Yes       No         Anxiety       Yes       No       Arthritis       Yes       No         Obsessive Compulsive Disorder       Yes       No       Neck, Back, Arm, Leg Problems       Yes       No         Thyroid Disease       Yes       No       HECTIOUS GASTROINTESTINAL       Yes       No         Diabetes       Yes       No       Heatitis       Yes       No         Thyroid Disease       Yes       No       Heatorn       Yes       No         Bleeding Tendency       Yes       No	•	🗆 Yes 🗆 No	Recent Chest Infection	🗆 Yes 🗆 No
Stroke  Yes  NoShortness of Breath on Exertion  Yes  NoSeizures  Yes  NoCough with Sputum  Yes  NoFainting  Yes  NoCough with Sputum  Yes  NoDizziness  Yes  NoSleep Apnea  Yes  NoHeadache  Yes  No- Use a C-PAP Machine  Yes  NoDouble Vision  Yes  No- Use a C-PAP Machine  Yes  NoDepression  Yes  NoMUSCULOSKELETAL  Yes  NoDepression  Yes  NoHerniated disc  Yes  NoAnxiety  Yes  NoArthritis  Yes  NoPsychiatric Care  Yes  NoRheumatoid  Yes  NoObsessive Compulsive Disorder  Yes  NoMeteration  Yes  NoDiabetes  Yes  No  Jaundice  Yes  NoThyroid Disease  Yes  NoHeartburn  Yes  NoTaken Steroids  Yes  NoHeartburn  Yes  NoBeeding Tendency  Yes  NoHeartburn  Yes  NoEasy Bruising  Yes  NoUrinary Disease  Yes  NoBleod clots in Lungs  Yes  NoUrinary Disease  Yes  NoBlood clots in Lungs  Yes  NoIf female, could you be pregnant?  Yes  NoBlood clots in Lungs  Yes  NoIf female,	Comments:		<ul> <li>Shortness of Breath</li> </ul>	🗆 Yes 🗆 No
Seizures        Yes       No       Cough        Yes       No         Fainting        Yes       No       Cough with Sputum        Yes       No         Dizziness        Yes       No       Sleep Apnea        Yes       No         Headache        Yes        No       -Use a C-PAP Machine        Yes        No         Double Vision        Yes        No       -Use a C-PAP Machine        Yes        No         Double Vision        Yes        No       MUSCULOSKELETAL        Yes        No         Depression        Yes        No       Herniated disc        Yes        No         Anxiety        Yes        No       Arthritis        Yes        No         Psychiatric Care        Yes        No       Neck, Back, Arm, Leg Problems        Yes        No         Obsessive Compulsive Disorder        Yes        No       Meandace        Yes        No         Thyroid Disease        Yes        No       Heantburn        Yes        No         Taken Steroids        Yes        No       Heartburn        Yes        No         Bleeding Tendency        Yes        No       Heartburn        Yes        No         Bl	NEUROLOGICAL		Shortness of Breath at Night	🗆 Yes 🗆 No
Fainting       \Pes       \No       Cough with Sputum       \Pes       \No         Dizziness       \Pes       \No       Sleep Apnea       \Pes       \No         Headache       \Pes       \No       -Use a C-PAP Machine       \Pes       \No         Double Vision       \Pes       \No       -Use a C-PAP Machine       \Pes       \No         Double Vision       \Pes       \No       MUSCULOSKELETAL       \Pes       \No         Depression       \Pes       \No       Herniated disc       \Pes       \No         Anxiety       \Pes       \No       Arthritis       \Pes       \No         Psychiatric Care       \Pes       \No       Neck, Back, Arm, Leg Problems       \Pes       \No         Obsessive Compulsive Disorder       \Pes       \No       Neck, Back, Arm, Leg Problems       \Pes       \No         ENDOCRINE       INFECTIOUS GASTROINTESTINAL       INFECTIOUS GASTROINTESTINAL       \No       \No         Taken Steroids       \Pes       \No       Heantitis       \Pes       \No         HEMATOLOGIC/ONCOLOGIC/	Stroke	🗆 Yes 🗆 No	Shortness of Breath on Exertion	🗆 Yes 🗆 No
Dizziness       \frac{\} \neq}}} \n	Seizures	🗆 Yes 🗆 No	Cough	🗆 Yes 🗆 No
Headache       \_Yes       \_No      Use a C-PAP Machine       \_Yes       \_No         Double Vision       \_Yes       \_No       MUSCULOSKELETAL         PSYCHIATIC       Sciatica       \_Yes       \_No         Depression       \_Yes       \_No       Herniated disc       \_Yes       \_No         Anxiety       \_Yes       \_No       Arthritis       \_Yes       \_No         Psychiatric Care       \_Yes       \_No       No       Netwatoid       \_Yes       \_No         Obsessive Compulsive Disorder       \_Yes       \_No       Netwatoid       \_Yes       \_No         ENDOCRINE       INFECTIOUS GASTROINTESTINAL       INFECTIOUS GASTROINTESTINAL       \_Yes       \_No         Diabetes       \_Yes       \_No       Hepatitis       \_Yes       \_No         Thyroid Disease       \_Yes       \_No       Heartburn       \_Yes       \_No         Bleeding Tendency       \_Yes       \_No       Heartburn       \_Yes       \_No         Easy Bruising       \_Yes       \_No       Kidney Disease       \_Yes       \_No         Blood clots in Legs       \_Yes       \_No       Kidney Disease       \_Yes       \_No         Blood c	Fainting	🗆 Yes 🗆 No	Cough with Sputum	🗆 Yes 🗆 No
Double Vision       \Pert       No       MUSCULOSKELETAL         PSYCHIATIC       Sciatica       \Pert       \No         Depression       \Pert       \No       Herniated disc       \Pert       \No         Anxiety       \Pert       \No       Arthritis       \Pert       \No         Psychiatric Care       \Pert       \No       Rheumatoid       \Pert       \No         Obsessive Compulsive Disorder       \Pert       \No       Neck, Back, Arm, Leg Problems       \Pert       \No         Obsessive Compulsive Disorder       \Pert       \No       Neck, Back, Arm, Leg Problems       \Pert       \No         Diabetes       \Pert       \No       Hecatibac       \Pert       \No         Taken Steroids       \Pert       \No       Ulcers       \Pert       \No         HEMATOLOGIC/ONCOLOGIC/       Hiatal Hernia       \Pert       \No         Bleeding Tendency       \Pert       \No       \URINARY/REPRODUCTIVE         Anemia       \Pert       \No       \Urinary Disease       \Pert       \No         Blood clots in Legs       \Pert       \No       \Urinary Disease       \Pert       \No         Blood clots in Lungs       \Pert       \No       \U	Dizziness	🗆 Yes 🗆 No	Sleep Apnea	🗆 Yes 🗆 No
PSYCHIATIC       Sciatica       Yes       No         Depression       Yes       No       Herniated disc       Yes       No         Anxiety       Yes       No       Arthritis       Yes       No         Psychiatric Care       Yes       No       Rheumatoid       Yes       No         Obsessive Compulsive Disorder       Yes       No       Neck, Back, Arm, Leg Problems       Yes       No         ENDOCRINE       INFECTIOUS GASTROINTESTINAL       INFECTIOUS GASTROINTESTINAL       Diabetes       Yes       No         Diabetes       Yes       No       Hepatitis       Yes       No         Thyroid Disease       Yes       No       Hepatitis       Yes       No         Taken Steroids       Yes       No       Heartburn       Yes       No         Bleeding Tendency       Yes       No       Heartburn       Yes       No         Easy Bruising       Yes       No       Kidney Disease       Yes       No         Blood clots in Legs       Yes       No       Kidney Disease       Yes       No         Blood clots in Lungs       Yes       No       Infermale, could you be pregnant?       Yes       No         Radiation Therap	Headache	🗆 Yes 🗆 No	— Use a C-PAP Machine	🗆 Yes 🗆 No
Depression         Yes       No       Herniated disc         Yes       No         Anxiety         Yes       No       Arthritis         Yes       No         Psychiatric Care         Yes       No       Rheumatoid         Yes         No         Obsessive Compulsive Disorder         Yes         No       Neck, Back, Arm, Leg Problems         Yes         No         ENDOCRINE       INFECTIOUS GASTROINTESTINAL       INFECTIOUS GASTROINTESTINAL         Yes         No         Diabetes         Yes         No       Heunatice         Yes         No         Thyroid Disease         Yes         No       Hepatitis         Yes         No         Taken Steroids         Yes         No       Heartburn         Yes         No         Bleeding Tendency         Yes         No       Haartburn         Yes         No         Easy Bruising         Yes         No       Kidney Disease         Yes         No         Blood clots in Legs         Yes         No       Kidney Disease         Yes         No         Blood clots in Lungs         Yes         No       Mumber of live births	Double Vision	🗆 Yes 🗆 No	MUSCULOSKELETAL	
AnxietyYesNoArthritisYesNoPsychiatric CareYesNoRheumatoidYesNoObsessive Compulsive DisorderYesNoNeck, Back, Arm, Leg ProblemsYesNoENDOCRINEINFECTIOUS GASTROINTESTINALINFECTIOUS GASTROINTESTINALDiabetesYesNoJaundiceYesNoThyroid DiseaseYesNoHepatitisYesNoTaken SteroidsYesNoUlcersYesNoHEMATOLOGIC/ONCOLOGIC/YesNoHeartburnYesNoBleeding TendencyYesNoURINARY/REPRODUCTIVENoAnemiaYesNoUrinary DiseaseYesNoSickle Cell DiseaseYesNoDialysisYesNoBlood clots in LegsYesNoIf female, could you be pregnant?YesNoBlood clots in LungsYesNoMumber of live birthsYesNoEYESCataractsYesNoDate of last mammogramNoNo	PSYCHIATIC		Sciatica	□ Yes □ No
Psychatric Care         Yes       No       Rheumatoid         Yes         No         Obsessive Compulsive Disorder         Yes         No       Neck, Back, Arm, Leg Problems         Yes         No         ENDOCRINE       INFECTIOUS GASTROINTESTINAL         Yes         No       Jaundice         Yes         No         Diabetes         Yes         No       Hepatitis         Yes         No         Thyroid Disease         Yes         No       Hepatitis         Yes         No         Taken Steroids         Yes         No       Ulcers         Yes         No         HEMATOLOGIC/ONCOLOGIC/         Yes         No       Heartburn         Yes         No         Bleeding Tendency         Yes         No       Kidney Disease         Yes         No         Easy Bruising         Yes         No       URINARY/REPRODUCTIVE         No         No         Sickle Cell Disease         Yes         No       Urinary Disease         Yes         No         Blood clots in Legs         Yes         No       If female, could you be pregnant?         Yes         No         Radiation Therapy         Yes         No       Number of live births	Depression	🗆 Yes 🗆 No	Herniated disc	🗆 Yes 🗆 No
Obsessive Compulsive Disorder       \frac{\frac{1}{2}}{18}       \frac{1}{28}       \frac{1}{28}	Anxiety	🗆 Yes 🗆 No	Arthritis	□ Yes □ No
Obsessive Compulsive Disorder       \frac{\frac{1}{2}}{18}       \frac{1}{28}       \frac{1}{28}	Psychiatric Care	🗆 Yes 🗆 No	Rheumatoid	🗆 Yes 🗆 No
Diabetes  Yes  NoJaundice  Yes  NoThyroid Disease  Yes  NoHepatitis  Yes  NoTaken Steroids  Yes  No  Ulcers  Yes  NoHEMATOLOGIC/ONCOLOGIC/  Yes  NoHeartburn  Yes  NoBleeding Tendency  Yes  NoHeartburn  Yes  NoEasy Bruising  Yes  NoURINARY/REPRODUCTIVE  Yes  NoSickle Cell Disease  Yes  NoUrinary Disease  Yes  NoBlood clots in Legs  Yes  NoDialysis  Yes  NoBlood clots in Lungs  Yes  NoIf female, could you be pregnant?  Yes  NoRadiation Therapy  Yes  NoNumber of live births		🗆 Yes 🗆 No	Neck, Back, Arm, Leg Problems	🗆 Yes 🗆 No
Thyroid Disease       Yes       No       Hepatitis       Yes       No         Taken Steroids       Yes       No       Ulcers       Yes       No         HEMATOLOGIC/ONCOLOGIC/       Yes       No       Heartburn       Yes       No         Bleeding Tendency       Yes       No       Heartburn       Yes       No         Easy Bruising       Yes       No       URINARY/REPRODUCTIVE         Anemia       Yes       No       Kidney Disease       Yes       No         Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       If female, could you be pregnant?       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births       Number of pregnancies       Yes       No         EYES       Cataracts       Yes       No       Date of last mammogram       Date of last mammogram       Date of last mammogram	ENDOCRINE		INFECTIOUS GASTROINTESTINAL	
Taken Steroids       Yes       No       Ulcers       Yes       No         HEMATOLOGIC/ONCOLOGIC/       Yes       No       Hiatal Hernia       Yes       No         Bleeding Tendency       Yes       No       Heartburn       Yes       No         Easy Bruising       Yes       No       URINARY/REPRODUCTIVE       No         Anemia       Yes       No       Kidney Disease       Yes       No         Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       If female, could you be pregnant?       Yes       No         Blood clots in Lungs       Yes       No       Number of live births       No         Radiation Therapy       Yes       No       Number of pregnancies       Yes       No         EYES       Yes       No       Date of last mammogram       Luce       Luce       Ne	Diabetes	🗆 Yes 🗆 No	Jaundice	🗆 Yes 🗆 No
HEMATOLOGIC/ONCOLOGIC/       Hiatal Hernia       Yes       No         Bleeding Tendency       Yes       No       Heartburn       Yes       No         Easy Bruising       Yes       No       URINARY/REPRODUCTIVE       No       Sickle Cell Disease       Yes       No         Anemia       Yes       No       Kidney Disease       Yes       No         Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       Dialysis       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births	Thyroid Disease	🗆 Yes 🗆 No	Hepatitis	🗆 Yes 🗆 No
Bleeding Tendency       Yes       No       Heartburn       Yes       No         Easy Bruising       Yes       No       URINARY/REPRODUCTIVE       No         Anemia       Yes       No       Kidney Disease       Yes       No         Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       Dialysis       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births       No         EYES       Cataracts       Yes       No       Date of last mammogram       Image: Date of last mammogram	Taken Steroids	🗆 Yes 🗆 No	Ulcers	🗆 Yes 🗆 No
Bleeding Tendency       \frac{1}{4} Yes       \frac{1}{6} No       Heartburn       \frac{1}{4} Yes       \frac{1}{6} No         Easy Bruising       \frac{1}{4} Yes       \frac{1}{6} No       URINARY/REPRODUCTIVE       \frac{1}{6} Yes       \frac{1}{6} No         Anemia       \frac{1}{6} Yes       \frac{1}{6} No       Kidney Disease       \frac{1}{6} Yes       \frac{1}{6} No         Sickle Cell Disease       \frac{1}{6} Yes       \frac{1}{6} No       Urinary Disease       \frac{1}{6} Yes       \frac{1}{6} No         Blood clots in Legs       \frac{1}{6} Yes       \frac{1}{6} No       Dialysis       \frac{1}{6} Yes       \frac{1}{6} No         Blood clots in Lungs       \frac{1}{7} Yes       \frac{1}{6} No       If female, could you be pregnant?       \frac{1}{7} Yes       \frac{1}{6} No         Radiation Therapy       \frac{1}{7} Yes       \frac{1}{6} No       Number of live births	HEMATOLOGIC/ONCOLOGIC/		Hiatal Hernia	🗆 Yes 🗆 No
Easy Bruising       Yes       No       URINARY/REPRODUCTIVE         Anemia       Yes       No       Kidney Disease       Yes       No         Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       Dialysis       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births		🗆 Yes 🗆 No	Heartburn	🗆 Yes 🗆 No
Anemia       Yes       No       Kidney Disease       Yes       No         Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       Dialysis       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births	÷ .	□ Yes □ No	URINARY/REPRODUCTIVE	
Sickle Cell Disease       Yes       No       Urinary Disease       Yes       No         Blood clots in Legs       Yes       No       Dialysis       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births	, 0			□ Yes □ No
Blood clots in Legs       Yes       No       Dialysis       Yes       No         Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births       Yes       No         EYES       Yes       No       Date of last mammogram       Date of last mammogram       Yes       No	Sickle Cell Disease	🗆 Yes 🗆 No		□ Yes □ No
Blood clots in Lungs       Yes       No       If female, could you be pregnant?       Yes       No         Radiation Therapy       Yes       No       Number of live births	Blood clots in Legs			
Radiation Therapy     □ Yes     □ No     Number of live births       EYES     Number of pregnancies       Cataracts     □ Yes     □ No   Date of last mammogram	0	□ Yes □ No		□ Yes □ No
EYES     Number of pregnancies       Cataracts     Yes       No     Date of last mammogram	-	🗆 Yes 🗆 No		
Cataracts 🗆 Yes 🗆 No Date of last mammogram	A 7			
		□ Yes □ No		
	Glaucoma	$\Box$ Yes $\Box$ No	Date of last menses (period)	

# Assignment and Release

I, the undersigned, have insurance coverage with \_\_\_\_\_\_\_ and assign directly to Frederick Eko, M.D., Inc. DBA Eko Plastic Surgery, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

