GORDON H. SASAKI, M.D., F.A.C.S.

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PLEASE PRINT

Date_____

Patient's Name___ _____ Age _____ Date of Birth_____

Home Address_____ City_____ State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

May we contact you at HOME? _____ WORK?_____ CELL?_____ EMAIL?_____

Email_____

Married _____ Single _____ Widowed _____ Divorce _____ Separated _____

Patient's Occupation _____Employer _____

Business Address _____Business Phone (_____) _____

Name of Spouse _____ Spouse's Occupation _____

Spouse's Employer _____

Spouses Business Address _____ Business Phone (_____) _____

Patient Referred By _____ Phone Number (_____) _____

May we send a Thank You to the person who referred you? Yes_____ No_____

Family Doctor or Internist _____ Phone Number (_____) _____

Doctors Address _____

For emergency notification please list a relative not living at the same address as patient

Nearest Relative and Address_____ Phone Number (_____) _____

If patient is a minor, please complete the following on the financially responsible party:

Name _____ Relationship _____

Address _____ City_____ State_____ Zip _____

Occupation _____ Employer_____

Business Address _____ Business Phone (_____) _____

PRESENT PROBLEM

Specific Problem(s) For Which You Are Seeking Plastic Surgery

_____

Have You Consulted Any Other Doctors, Including Plastic Surgeons, About This? No _____ Yes _____

If Yes, Please List Their Names _____

*PLEASE BE ADVISED THAT DOCTOR SASAKI DOES NOT PARTICIPATE IN ANY INSURANCE PLANS

INJURIES

Type	Year	Hospital	Doctor	After Effects

FAMILY HISTORY

	Age	State of Health
Mother		
Father		
Brother (s)		
Sister(s)		
Children		

HAS ANY RELATIVE HAD:

Blood or Bleeding Disorders	No _____ Yes _____
Tuberculosis	No_____ Yes_____
Cancer	No _____ Yes _____
Diabetes	No _____ Yes _____
Epilepsy	No _____ Yes _____
Heart Disease	No _____ Yes _____
High Blood Pressure	No _____ Yes _____
Lung Disease	No _____ Yes _____
Kidney Disease	No _____ Yes _____
Asthma	No _____ Yes _____
Mental Disease	No _____ Yes _____

MEDICATONS, DRUGS

ARE YOU ALLERGIC TO ANY MEDICATIONS? Please list and describe symptoms and reactions to each medication:

_____

_____

What is your daily consumption of the following:

Coffee or Tea _____ Alcohol _____ Tobacco _____

Other intoxicating or mind altering drugs (specify) _____

Does anyone else in your household smoke? No _____ Yes _____ How much? _____

Please list ALL your medications and their dosages including BIRTH CONTROL PILLS, DIURETICS, BLOOD PRESSURE OR HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS/SPRAYS, INHALER MEDICINES, RUB-ON MEDICATIONS, ASPIRIN, BUFFERIN, SUPPLEMENTS, HERBS, AND VITAMINS, ETC.

_____

_____

PAST MEDICAL HISTORY

General Health Good_____ Fair _____ Poor _____

If Not "Good", please explain:

_____

Height _____ Weight _____ Weight Loss or Gain in past year _____ lb. Loss _____ Gain_____

History of Hepatitis, Jaundice, Blood infections or disorders, HIV? _____

Serious Illnesses (Please List)

_____

_____

PREVIOUS SURGERY (please list)

Operation	Year	Hospital	City	Surgeon's Name/ Type of Anesthesi (Local or General)

Have you had any significant Complications or after effects of these operations? No _____ Yes _____

If "Yes", Please Explain

_____

PERMANENT PREOPERATIVE INFORMATION

Have you ever reacted badly to being put to sleep for surgery?	No _____ Yes _____
Has any member of your family ever reacted badly to being put to sleep for surgery?	No _____ Yes _____
Have you required unusually large amounts of local anesthetic for medical or dental procedures?	No _____ Yes _____
Have you ever had a reaction to a local anesthetic (Novocain, etc.)?	No _____ Yes _____
Are you allergic to adhesive tape?	No _____ Yes_____
Are you allergic to adhesive material such as catgut?	No _____ Yes _____
Do you have high blood pressure?	No _____ Yes _____
Have you ever had scarlet fever or rheumatic fever?	No _____ Yes _____
Do you bleed unusually easily (from cuts, surgery, and tooth extractions)?	No _____ Yes _____
Do You Bruise Unusually Easily?	No _____ Yes _____
Are You a Slow or Poor Healer?	No _____ Yes _____
Do You Form Large Scars or Keloids?	No _____ Yes _____
Do You Have Any Skin Diseases, Hives, Eczema, or Rash?	No _____ Yes _____
Do You Have Frequent Infections or Boils?	No _____ Yes _____
Have You Taken Steroid Medications, Accutane, Cortisone, or ACTH? If so, how long ago?	No _____ Yes _____
Do You Have Shortness of Breath With Walking?	No _____ Yes _____
Do You Have, or Have You Had Any Back Trouble?	No _____ Yes _____
Does Your Religion Prohibit Blood Transfusions?	No _____ Yes _____
Do You Have or Have You Had Any Significant Emotional Problems?	No _____ Yes _____
Have You Ever Had, or Been Advised to Seek Psychiatric Care?	No _____ Yes _____

Have You Had Any Illnesses or Disorders of the Following? (Circle if Yes)

*Brain (Including Strokes, Epilepsy) * Face *Heart or Blood Vessels *Blood (Diabetes, Hepatitis, HIV) *Arms or Legs
*Nervous System *Nose, Sinus, Throat *Stomach *Urinary System *Bones or Joints
*Eyes (Including Glaucoma, Dryness) *Breasts *Intestines *Reproductive System *Endocrine System or Diabetes
*Ears * Lungs (Including Asthma) * Liver

If Circled, Please Explain:

_____

_____

_____

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Patient **OR** Guardian Signature:_____

Print Name: _____ Date: _____

Consent for Consultation and/or Treatment I Consent to the Care and Treatment by Gordon H. Sasaki, M.D., his Registered Nurses, his Surgical Team, or Skin Care Specialists

Patients **OR** Guardian Signature:_____

Print Name: _____ Date: _____

PHOTOGRAPHIC RELEASE AND CONSENT

I authorize Gordon Sasaki, M.D. to use my photographs, videotapes and case information in the following educational and scientific settings that I have initialed: Declining photographic consent will in no way affect the doctor/patient relationship or treatment. I understand and accept that I may be recognized from my likeness or case history

Yes No

_____ _____ Lectures and multi- media presentations for an audience of medical professionals but at which members of the press may be present.

_____ _____Lectures and multi-media presentations given by my surgeon for the general public

_____ _____ Medical, surgical and scientific journal articles

Yes No

_____ _____Dr. Sasaki's personal web site or web page

_____ _____ Dr. Sasaki's Facebook and Instagram page

_____ _____Dr. Sasaki's office patient education materials

_____ _____Newspaper and magazine articles in which my surgeon participates

_____ _____Television programs in which my surgeon participates

I also authorize Dr. Sasaki's professional association, such as the non-profit American Society for Aesthetic Plastic Surgery, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

Yes No

_____ _____Patient education brochures available for purchase

_____ _____Educational DVD available for purchase

_____ _____Lectures and slide presentations available for purchase

_____ _____Information submitted by the society to consumer periodicals and magazines for publication

_____ _____Television programs about plastic surgery

_____ _____Case studies presented on the society's web site at www.surgery.org

_____

Patient **OR** Guardian Signature Date

_____

Print Name