GORDON H. SASAKI, M.D., F.A.C.S.
Diplomate of
American Board of Plastic Surgery

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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 AND DOCTOR HAKIMI**

DO 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:

_____

_____

_____

***PLEASE BE ADVISED THAT DOCTOR SASAKI AND DOCTOR HAKIMI**

***DO NOT PARTICIPATE IN ANY INSURANCE PLANS**

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., Michael Hakimi, M.D., their Registered Nurses, Surgical Team, or Skin Care Specialists

Patients **OR** Guardian Signature:_____

Print Name: _____ Date: _____

PHOTOGRAPHIC RELEASE AND CONSENT

I authorize Gordon Sasaki, M.D. and Michael Hakimi, 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(s) for the general public

_____ _____ Medical, surgical and scientific journal articles

Yes No

_____ _____Dr. Sasaki's and Dr. Hakimi's personal web site or web page

_____ _____ Dr. Sasaki's and Dr. Hakimi's Facebook and Instagram page

_____ _____Dr. Sasaki's and Dr. Hakimi's office patient education materials

_____ _____Newspaper and magazine articles in which my surgeon(s) participates

_____ _____Television programs in which my surgeon(s) participates

_____

Patient **OR** Guardian Signature Date

_____

Print Name