GREG K. SAKAMOTO, M.D. *DERMATOLOGY*

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Patient Medical History Form (1 of 2)

NAME: _____ **DATE OF BIRTH:** _____

Primary Care Physician: _____ **Referred by Physician?:** □Yes □No **Physician Name:** _____

If not referred by Physician, how did you hear about us? _____

Reason for today's visit: _____

Past Medical History: (please **circle** all that apply) □ **None**

Anxiety	Coronary Artery Disease	Hypothyroidism
Arthritis	Depression	Leukemia
Artificial joints	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD (Acid Reflux)	Pacemaker
BPH (Benign Prostatic Hyperplasia)	Hearing Loss	Prostate Cancer
	Hepatitis B, Hepatitis C	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD (Emphysema)	Hyperthyroidism	

Other: _____

Past Surgical History: (please **circle** all that apply) □ **None**

Appendix Removed	PTCA	Ovaries Removal:
Bladder Removed	Mechanical Valve Replacement	-Ovarian Cancer
Mastectomy (Right, Left, Both)	Biological Valve Replacement	Prostate Removal:
Heart Transplant (Right, Left, Both)	TURP	-Prostate Cancer
Lumpectomy (Right, Left, Both)	Breast Reduction	-Prostate Biopsy
Breast Biopsy (Right, Left, Both)	Breast Implants	Testicle Removal (Right, Left, Both)
Skin Biopsy	Kidney Biopsy	Hysterectomy: Fibroids
MOHs	Kidney Removal (Right, Left)	Hysterectomy: Uterine Cancer
Skin Excision	Spleen Removal	Kidney Stone Removal
Kidney Transplant	Gallbladder Removal	Colectomy: Diverticulitis
Colectomy: Colon Cancer Resection	Colectomy: IBD	Ovaries Removed: Cyst
Ovaries Removed: Endometriosis	Joint Replacement, Hip (Right, Left, Both)	
Joint Replacement (within last 2 years)		

Other: _____

Skin Disease History: (please **circle** all that apply) □ **None**

Acne	Blistering Sunburns	Melanoma
Actinic Keratosis	Dry Skin	Precancerous Moles
Autoimmune Diseases	Eczema	Psoriasis
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Squamous Cell Skin Cancer

Other: _____

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Patient Medical History Form (2 of 2)

Do you wear Sunscreen? YES NO If yes, what SPF? _____
Do you tan in a tanning salon? YES NO
Do you have a family history of melanoma? YES NO
If yes, which relative(s)? _____
Any other family history of skin disease: _____

Medications: (Please enter **all** current medications or provide list) ☐ **None**

Name/Dosage::

_____

_____

Allergies: (Please enter **all** allergies and the reaction you experience) ☐ **No Known Drug Allergies**

_____

Social History: (Please **circle** all that apply) ☐ **None**

Where were you born and raised?: _____ Marital Status: _____
Occupation/Workplace/School: _____

Cigarette Smoking:	Alcohol Use:	Sexual Activity:
Never smoked	YES NO	Not sexually active
Quit: former smoker		Sexually active with one partner
Smokes less than daily	Recreational IV drug use:	Sexually active with multiple partners
Smokes daily	YES NO	Same sex partner

Pregnant or planning to become pregnant (circle one): YES NO if "YES", how many weeks?; _____

Review of Systems: (please **circle** all that apply)

Problems with bleeding	Problems with healing	Problems with scarring
History of rash	Headaches	Artificial heart valve
Artificial joints	Blood thinners	Defibrillator
Joint ache	Pacemaker	

Family History: (ex. Diabetes, Hypertension, Breast Cancer)

_____

Preferred Pharmacy: _____(prescriptions will be faxed to the pharmacy listed)

Do we have permission to leave messages on: (please **circle** all that apply) Home Work Cell

Ok to discuss medical condition(s) with a member(s) of your household:

_____
(Name and Relationship)

I attest that this form is accurate and complete to the best of my knowledge.

_____ _____
(Patient/Parent/Guardian Signature) (Date)