SAKAMOTO
DERMATOLOGY

WWW.SAKAMOTODERMATOLOGY.COM
Queens Physicians Office Building III
550 S. Beretania St. Suite 603, Honolulu, HI 96813
Office: (808) 447-7454 · Fax (808) 447-7456

PATIENT MEDICAL UPDATE

Last Name:____________________________ First Name:____________________________ DOB:____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address:____

City:____________________________ State:____________ Zip Code:____________

Home #:__________________________ Work #:__________________________ Mobile #:____________________

Preferred Daytime Phone: ☐ Home ☐ Work ☐ Mobile / Ok to leave a message: ☐ Yes ☐ No

******Selecting "YES" allows the office to leave a message regarding sensitive medical information on your voicemail, such as lab/pathology results, etc.***

E-Mail Address:____

******NOTE: Patient Portal Access is set up via email - you will be able to participate with on-line billing, appointment requests, telehealth visits, etc.***

☐ **No Insurance/Self Pay**

Primary Insurance:____________________________ Policy ID:____________________________

Secondary Insurance:____________________________ Policy ID:____________________________

Emergency Contact: (Limited information will be provided to persons' listed below in the event of an emergency within our office.)

Name:________________________ Relationship:____________________Emergency Phone:__________________

Name:________________________ Relationship:____________________Emergency Phone:__________________

****

Primary Care Physician:____

Preferred Pharmacy:____(Prescriptions will be E-faxed to the pharmacy listed)

Authorize healthcare information to be discussed with household members? ☐ Yes ☐ No

******Selecting "YES" allows the office to discuss any and all medical information with the persons listed below, such as lab/pathology results, medications, etc. This does not apply to minor(s) 0-17 years of age, unless otherwise specified (e.g. TRO's, Custody Agreements) or for other persons besides parents/legal guardians.***

If yes, please inform us of who : Name:__________________ Relationship:________________ Contact #:____________

Name:__________________ Relationship:________________ Contact #:____________

****

Cigarette Smoking: ☐ None ☐ Current ☐ Former : Quit Date:_________ ☐ Occasionally

Vaping: ☐ None ☐ Current ☐ Former : Quit Date:_________ ☐ Occasionally

Recreational Drug(s): ☐ None ☐ Current ☐ Former : Quit Date:_________ ☐ Occasionally

Alcohol Use: ☐ None ☐ Less than 1 drink/day ☐ 1-2 drinks/day ☐ 3 or more drinks/day

Employment: ☐ Not Applicable ☐ Self ☐ Retired ☐ Full-Time ☐ Part-Time **Occupation:**__________________________

Student: ☐ Not Applicable ☐ Full-Time ☐ Part-Time **School:**__________________________

Pregnant or planning to become pregnant: ☐ Yes ☐ No If **Pregnant**, how many weeks?:_______________

Have you received your annual flu vaccination? ☐ Yes ☐ No / **Have you received a COVID vaccination?** ☐ Yes ☐ No

Are you 65 or over? ☐ Yes ☐ No **(If "NO", no further questions)**

Have you received a pneumonia vaccination? ☐ Yes ☐ No

Do you have a health proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Which best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate ☐ Do Not Resuscitate ☐ Full Cardiopulmonary Resuscitation

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Medical History: (Please **CHECK** all that apply) ☐ **NONE / Current Height: ___________ Current Weight:___________**

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benign Prostatic Hyperplasia
☐ Cerebrovascular Accident (Stroke)
☐ Coronary Arteriosclerosis
☐ Depressive Disorder
☐ Diabetes Mellitus
☐ Disease related by COVID
☐ Elevated Blood Pressure
☐ End Stage Renal Disease
☐ Epilepsy
☐ GERD
☐ Hearing Loss
☐ HIV
☐ High Cholesterol
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Inflammatory Disease of Liver
☐ Leukemia
☐ Malignant Lymphoma
☐ Malignant tumor of Lung(s)
☐ Malignant tumor of Breast
☐ Malignant tumor of Colon
☐ Malignant tumor of Prostate
☐ Transplant of Bone Marrow
☐ Radiation Therapy

Other:____

Past Surgeries: (Please **CHECK** all that apply) ☐ **NONE**

☐ Abdominal resection
☐ Bilateral replacement of knee joints
☐ Biopsy of breast
☐ Biopsy of prostate
☐ Coronary artery bypass graft
☐ Entire transplanted kidney
☐ Excision of basal cell carcinoma
☐ Excision of melanoma
☐ Excision of squamous cell carcinoma
☐ H/O colostomy
☐ H/O tubal ligation
☐ H/O appendectomy
☐ H/O bilateral mastectomy
☐ H/O cholecystectomy
☐ H/O colectomy
☐ H/O liver excision
☐ H/O coronary angioplasty
☐ H/O heart valve replacement
☐ H/O cystectomy
☐ H/O transurethral prostatectomy
☐ Hysterectomy
☐ Kidney biopsy
☐ Low anterior resection of rectum
☐ Lumpectomy of left breast
☐ Lumpectomy of right breast
☐ Mastectomy of left breast
☐ Mastectomy of right breast
☐ Mechanical heart valve replacement
☐ Oophorectomy
☐ Pancreatectomy
☐ Kidney stone removal
☐ Portosystemic shunt operation
☐ Prostatectomy
☐ Prosthetic arthroplasty of bilateral hips
☐ Splenectomy
☐ Total nephrectomy
☐ Total orchiectomy
☐ Left hip replacement
☐ Left knee replacement
☐ Right hip replacement
☐ Right knee replacement
☐ Transplantation of heart
☐ Transplantation of liver

Other:____

Medications: (Please list **ALL** current medications or provide list) ☐ **List Provided** ☐ **NONE**

_________________ _________________ _________________ _________________ _________________
_________________ _________________ _________________ _________________ _________________

Allergies: (Please list **ALL** allergies and reactions experienced) ☐**List Provided** ☐ **Seasonal ONLY** ☐ **NONE**

_________________ _________________ _________________ _________________ _________________

My signature below indicates that I have received, reviewed, and agreed to the policies set forth on the forms titled: (1) *Financial and Office Policies*, and (2) *Notice of Privacy Practices*. I attest that this form is accurate and complete to the best of my knowledge. I hereby authorize the release of any medical information necessary to process claims pertinent to my care with Greg K. Sakamoto, MD and I authorize my insurance benefits to be paid directly to this practice and acknowledge that I am financially responsible for any unpaid balance.

____ ____________________
(Patient/Parent/Guardian Signature) **(Date)**