NORTHEAST PLASTIC SURGERY
CENTER
5 Davis Road East
Old Lyme, CT 06371
Tel 860.390.6000
Fax 860.215.8150
info@northeastpsc.com
www.northeastpsc.com
Vinod V. Pathy, MD, FACS
Megan J. Phillips, PA-C

Patient History

Name: _____ Date:_____

Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Physician: _____

Reason for Visit: _____

Medical History (check all that apply):

Eyes: □Field of vision problems □Glaucoma □Cataracts □Dry eyes
Breast: □Benign breast disease (i.e. breast lumps)
Breast Cancer: □Right □Left when? _____ □Chemotherapy □Radiation
Cardiovascular: □High Blood Pressure □Heart Attack: when? _____
□CHF □Coronary Artery Disease □Arrhythmia
□Peripheral Vascular Disease □High Cholesterol
Lungs: □COPD/emphysema □Asthma
Endocrine: □Diabetes □Thyroid: hypo (low) or hyper (high)?
Kidney: □Kidney Disease □Dialysis
Neurologic: □Stroke □Lyme Disease
Blood: □DVT □Bleeding Problems
Skin: □Skin Cancer . . . . . what type and where? _____
□Rashes . . . . . where? _____
Psychiatric: □Depression □Anxiety
Infectious: □HIV □Hepatitis (A/B/C)
□ Other (explain):

_____

_____

Are you or could you be pregnant? □Yes □No
Are your menstrual periods regular? □Yes □No
Do you have a history of Herpes I or II in the area to be treated? □Yes □No
Do you have a history of keloid scarring (overly thickened scar)? □Yes □No
Have you taken Accutane or anticoagulants in the last 12 months? □Yes □No
Do you have permanent make-up, implants, or tattoos? If yes, list locations _____

_____

What is your current skin care regimen? _____

_____

Surgical History (with approximate dates):

Eyes: _____
Breast: _____
Lymph Node Surgery: _____
Cardiovascular (includes pacemaker and IVC filter):
_____
Lungs: _____
Abdominal Surgeries: _____
GYN (including C-section, tubal ligation): _____
Neurosurgery: _____
Thyroid/kidney: _____
Skin (i.e. cancer removal): _____
Other:_____

Cosmetic Procedures: □Blepharoplasty(eyelid lift) □Facelift □Rhinoplasty (nasal surgery)
Breast: □Reduction □Augmentation □Lift
□Abdominoplasty
□Liposuction: where? _____
□Laser Therapy/IPL/etc.
□ Other: _____

Allergies (medication/food/latex/other):
_____

Medications (with dosages) including Over-the-Counter medications, supplements, and topicals:
_____ _____
_____ _____
_____ _____

Social History:
Do you smoke cigarettes/cigars/pipes (circle one)? □ Yes □No
If Yes, how much and how often? _____
Do you use other nicotine products, such as nicotine gum or nicotine patch? □Yes □No
Do you drink alcohol? □Yes □No
If Yes, how much and how often? _____
Do you use any illicit drugs (medical confidentiality applies)? □Yes □No
If Yes, what drug and how often? _____

Family Illnesses (i.e. diabetes, high blood pressure, breast cancer, genetic testing, etc.):
_____

Approximate Height: _____ Approximate Weight: _____
Significant weight □ loss / □ gain, and **how much and over what time**? _____
For all breast surgery patients, what is your bra size?: _____

Preferred pharmacy: _____

Our practice may release my protected health information to:
Name: _____ Your Initials: _____
Name: _____ Your Initials: _____
Name: _____ Your Initials: _____