NORTHEAST PLASTIC SURGERY
CENTER

5 Davis Road East
Old Lyme, CT 06371

info@northeastpsc.com
www.northeastpsc.com

Tel 860.390.6000
Fax 860-215-8150

Tomer Avraham, MD, FACS **Vinod V. Pathy, MD, FACS** **Charles Karcutskie, MD**
Megan Phillips, PA-C **Hannah Chalmers, PA-C**

Patient History

Name ______________________ Date ______________

DOB ______________________ Age ______________

Referring Physician ______________________ Primary Physician ______________

Reason for Visit ____

Medical History (circle all that apply)

Eyes:	Field of vision issues	Glaucoma	Cataracts	Dry eyes
Breast:	Benign breast disease			
Breast Cancer:	Right	Left	*when?*	________
	Chemotherapy	Radiation		
Cardiovascular:	High blood pressure	Heart attack:	*when?*	________
	CHF	Coronary Artery Disease	Arrhythmia	High Cholesterol
	Peripheral Vascular Disease			
Lungs:	COPD/emphysema	Asthma		
Endocrine:	Diabetes	Thyroid:	*Low or High*	
Kidney:	Kidney disease	Dialysis		
Neurologic:	Stroke	Lyme Disease		
Blood:	DVT	Bleeding issues		
Skin:	Skin cancer:	*what type and where?*		________
Psychiatric:	Depression	Anxiety		
Infectious:	HIV	Hepatitis:	*A / B / C*	

Other (explain): ____

____

Medical History (continued)

Are you or could you be pregnant?	Yes	No
Are your menstrual period 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 makeup, implants, or tattoos? *If yes, list locations* ____________________

____

What is your current skin care regimen? ____________________

____

Surgical History (non-cosmetic) (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 (circle all that apply, with approximate dates)

Blepharoplasty (eyelid lift)	Facelift	Rhinoplasty (nasal surgery)
Breast reduction	Breast augmentation	Breast lift
Abdominoplasty		

Liposuction: where? ____________________

Laser Therapy/IPL/etc: *where?* ____________________

Other: ____________________

Allergies (medication/food/latex/other) and associated **reaction**

Medications (with dosages) including Over-the-Counter medications, supplements, topicals, injectable, and intravenous

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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 (circle one; medical confidentiality applies)?	Yes	No
If Yes, what drug and how often?		
Occupation and duties		

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

Approximate Height ____________ Approximate Weight ____________

Significant weight: *Loss?* *Gain?* How much/over what time? ____________

For all breast surgery patients, what is your bra size?

For all surgical patients, are you agreeable to receiving blood products if necessary? Yes No

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Preferred pharmacy ____________

Our practice may release my protected health information to:

Name ____________ Your initials ____________

Name ____________ Your initials ____________

Name ____________ Your initials ____________