



Vinod V. Pathy, MD, FACS
Aesthetic, Plastic, & Reconstructive Surgery

1525 Boston Post Road
Westbrook, CT 06498
860-333-1456 (O)
860-656-7104 (F)

1010 Village Walk
Guilford, CT 06437
860-333-1456 (O)
860-656-7104 (F)

330 Washington Street, Suite 410
Norwich, CT 06360
860-425-5300 (O)
860-425-5301 (F)

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? _____ Arrhythmia
- CHF Coronary Artery Disease
- Peripheral Vascular Disease
- 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 you 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 (include 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 (circle one) Abdominoplasty

Liposuction: where? _____

Laser Therapy/IPL Thermage

Botox Dermal Fillers

Other: _____

Allergies (medication/food/latex/other):

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

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

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? _____

Approximate Height: _____ Approximate Weight: _____

If any significant or recent weight: loss/ gain, how much and over what time? _____

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

Our practice may release my protected health information to:

Name: _____ Your Initials: _____

Name: _____ Your Initials: _____

Name: _____ Your Initials: _____