METROPOLITAN PLASTIC SURGERY

313 Park Avenue Suite 100A Falls Church, VA 22046 14908 Richmond Highway, Woodbridge, VA 22191

HEALTH QUESTIONNAIRE

RECONSTRUCTIVE PATIENT HISTORY QUESTIONNAIRE

All information is strictly confidential and will be released only with your written permission.

Last Name_____First_____Age_____Sex_____

Present Medical Condition

Current Health Status: _____

What is the primary reason for this visit? _____

What is the date of onset of your problem/Injury? _____

If due to injury, how did you injure yourself ? _____

Do you have any medical symptoms related to this problem? _____

Have you had surgery on this area before? _____

When was this treatment done? _____

What kind of treatment was done? _____

Have you ever injured this area before? _____If so, when? _____

Please list any other important fact about your present problem that you would like Dr.Marefat to know about _____

_____

Past Medical/Major Illness or Injury

Do you have heart disease? ☐ Y ☐ N
Do you have Diabetes? ☐ Y ☐ N
Do you have High blood pressure? ☐ Y ☐ N
Have you ever had a blood clot, deep vein thrombosis, or Pulmonary embolus? ☐ Y ☐ N
List any other illness or injury requiring hospitalization. Include approximate date.

_____

_____

Family History/Review of Systems

Do you and/or any family member have: (mark patient "p" and/or family member "f" or "none")

_____ Anemia/Blood Disorder
_____ Stomach/Bowel Disorder
_____ Arthritis
_____ Cancer
_____ Headaches
_____ Hypertension
_____ Jaundice/Hepatitis
_____ Thyroid Disease

_____ Respiratory Problems
_____ Epilepsy/Neurological Disorder
_____ Urinary Tract Problems
_____ Diabetes
_____ Heart Disease
_____ Varicose Veins

Surgical History

Name of Operation: _____Date: _____Complications:

_____

_____

Have you ever had bleeding problems? ☐ Y ☐ N
Have you ever had a blood transfusion? ☐ Y ☐ N Date: _____
Have you taken Aspirin or Motrin (Advil) in the past month? ☐ Y ☐ N Date: _____
Have you taken any Steroid containing medication recently (eg. Prednisone)? ☐ Y ☐ N Date: _____
Have you taken Vitamin E in the past month? ☐ Y ☐ N Date: _____
Have you been tested for HIV? ☐ Y ☐ N Date:_____
Result (optional)_____

Profession: _____

Allergies:

Name of Drug/Item: _____

_____

Medications:

Currently Take: _____

Personal Habits

Do you smoke or chew tobacco? ☐ Y ☐ N
No. packs/day:_____
Date started: _____ Date stopped: _____

Ever had a drinking problem? ☐ Y ☐ N
No./day: _____ No./week: _____
☐ wine ☐ beer ☐ hard liquor

Ever had a drug problem?
Ever used intravenous drugs? ☐ Y ☐ N
Date last used: _____

Do you exercise regularly? ☐ Y ☐ N
What do you do? _____
How often? _____ Duration: _____

Is your job a risk to your health? ☐ Y ☐ N
If yes, please explain: _____

_____

How much do you weigh? _____
How tall are you? _____

Social History

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Living with “significant other”
Do you have children? ☐ Y ☐ N
If yes, please list number and age(s): _____

_____

Hand Patients Only

Are you right or left handed?	☐ Right	☐ Left
Does your work entail repetitive hand motion?	☐ Y	☐ N
Did your injury occur on the job?	☐ Y	☐ N
Have you ever been treated hand injuries before?	☐ Y	☐ N
Do you have any numbness or tingling in your hand?	☐ Y	☐ N

If yes please describe: _____

Women only

Date of last menstrual period: _____

Are you pregnant?	☐ Y	☐ N

Date of last pregnancy: _____

Are you currently using contraception?	☐ Y	☐ N
Have you ever had a mammogram?	☐ Y	☐ N

Date:

What size bra do you wear? _____

What size cloths do you wear? _____

Has anyone in your family ever had breast cancer?	☐ Y	☐ N

Thank you for taking time to fill this questionnaire. Please review it and make sure that all questions are answered to the best of your knowledge.

Signature: _____ Date: _____