



# METROPOLITAN PLASTIC SURGERY

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## COSMETIC QUESTIONNAIRE

### COSMETIC 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? \_\_\_\_\_

How long have you been concerned about this problem? \_\_\_\_\_

What don't you like about this area of your body? \_\_\_\_\_

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): \_\_\_\_\_

**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: \_\_\_\_\_