Metropolis Medical
2351 Clay Street, Suite 512
San Francisco, CA 94115
Tel. 415-292-5477 Fax 415-292-5490

Date:	
Last Name:	Acct. #
Provider:	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:				
Date of Birth		**Age**		**Sexual Identity:** ☐ Male ☐ Female ☐ Male to Female ☐ Female to Male
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Previous or referring doctor:		**Date of last physical exam:**		
What is the main reason (s) for which you are seeing a physician?				

PERSONAL HEALTH HISTORY

Childhood illnesses.	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio					
Immunizations	☐ Tetanus	Date:	☐ Zostavax	Date:	☐ Hepatitis A	Date: [ ] 2 Shots
	☐ Pneumonvax	Date:	☐ HPV	Date:	☐ Hepatitis B	Date: [ ] 3 Shots
	☐ Influenza	Date:	☐ Yellow Fever	Date:	☐ TB Test	Date: [ ] + [ ] -
	☐ H1N1	Date:	☐ MMR	Date:	☐ OTHER	

List any medical problems that other doctors have diagnosed.

Last Dental Visit:

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

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List your prescribed medications and over-the-counter drugs, INCLUDING any vitamins and inhalers

Name	Strength	Frequency Taken

Allergies to Medications

Name	Reaction

FAMILY HEALTH HISTORY

CHECK ALL CIRCLE THAT APPLY: SELF, FATHER, MOTHER, BROTHER AND/OR SISTER

[ ] Tuberculosis	Self F M B S	[ ] Rheumatoid Arthritis	Self F M B S	[ ] Blood Disorders (Sickle Cell Anemia, etc)	
[ ] Asthma	Self F M B S	[ ] Heart Disease	Self F M B S	Type:	Self F M B S
[ ] Glaucoma	Self F M B S	[ ] High Blood Pressure	Self F M B S	[ ] Cancer	
[ ] Ulcer Disease	Self F M B S	[ ] Low Blood Pressure	Self F M B S	Type:	Self F M B S
[ ] Diabetes	Self F M B S	[ ] Bleeding Tendency	Self F M B S	Type:	Self F M B S

ILLNESSES AND OTHER PHYSICAL AILMENTS

Check if you have had any of the following illnesses or any symptoms in the areas to a significant degree.

[ ] Dizzy Spells
[ ] Ears
[ ] Glaucoma
[ ] Other Eye/Vision Problem
____
[ ] Sinus problems
[ ] Deafness/Decreased Hearing
[ ] Repeated Nose Bleeds
[ ] Chronic Nose
[ ] Obstruction
[ ] Swelling/Pain in the Neck
[ ] Asthma
[ ] Throat problems
[ ] Bronchitis
[ ] Emphysema
[ ] Pneumonia
[ ] Tuberculosis
[ ] Other Lung Problems:
____

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Bleed or Bruise Easily
[ ] Anemia
[ ] Circulation Problems
[ ] Inability to sleep
[ ] Heart Attack/ Stoke
[ ] Heart Murmur
[ ] Ankles Swell
[ ] Other Heart Condition
[ ] Headaches
[ ] Tiredness
[ ] Nervousness/Anxiety
[ ] Chest Pains
[ ] Shortness of Breath
[ ] Wheezing
[ ] Hypertension
[ ] Abdominal Pain
[ ] Cold Intolerance

[ ] Stomach/Duodenal
[ ] Ulcer
[ ] Hemorrhoids
[ ] Colitis
[ ] Diverticulitis
[ ] Other Bowel Problems
____
[ ] Gall Bladder Trouble
[ ] Back Problems
[ ] Other Pan/Discomfort
____
[ ] Diarrhea
[ ] Constipation
[ ] Bloody Stools
[ ] Blood in Urine
[ ] Gas (dyspepsia)
[ ] Heartburn
[ ] Dental Problems
[ ] Nausea/Vomiting

[ ] Hepatitis
[ ] Convulsion/Seizures
[ ] Arthritis
[ ] Diabetes
[ ] Paralysis
[ ] Skin
Recent Changes in:
[ ] Weight
Explain:______________________
[ ] Energy level
Explain:______________________
[ ] Sexual Performance Issues
[ ] Pain with Urination
[ ] Allergies______________________
____
[ ] OTHER______________________
____

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GENERAL HEALTH RELATED QUESTIONS							
Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you dieting?			☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?			☐	Yes	☐	No
	# of meals you eat in an average day?						
	Rank salt intake	☐ Hi	☐ Med	☐ Low			
	Rank fat intake	☐ Hi	☐ Med	☐ Low			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?			☐	Yes	☐	No
	If yes, what kind?						
	How many drinks per week?						
	Are you concerned about the amount you drink?			☐	Yes	☐	No
	Have you considered stopping?			☐	Yes	☐	No
	Have you ever experienced blackouts?			☐	Yes	☐	No
	Are you prone to "binge" drinking?			☐	Yes	☐	No
Tobacco	Do you use tobacco?			☐	Yes	☐	No
	If so, when did you start?		Currently smoke cigarettes or packs per day	Year Quit			
Drugs	Do you currently use recreational or street drugs?			☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?			☐	Yes	☐	No
Sexual Orientation	[ ] Strictly Heterosexual	[ ] Strictly Homosexual	[ ] Bisexual				
	How many sexual partners have you had in the last **3 months**?	**Last year?**	**Lifetime?**				
ID Medical History	**Please indicate if you have been tested for any of the following and when your last test was.**						
	Hepatitis A	Chlamydia					
	Hepatitis B	HIV					
	Hepatitis C	Syphilis					
	Gonorrhea	Tuberculosis					
	Please indicate of you have been treated for any of the following and when.						
	Genital Warts	Gonorrhea					
	Syphilis	Hepatitis A					
	Intestinal Parasites	Hepatitis B					
	MRSA	Hepatitis C					
	Tuberculosis	HIV					
Personal Safety	Do you live alone?			☐	Yes	☐	No
	Do you have frequent falls?			☐	Yes	☐	No

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SOCIAL HISTORY				
City and State you were born in?				
Highest Education Level	☐ Primary/High School	☐ Some College	☐ College Graduate	☐ Post Graduate
I am currently	☐ Employed/Position ______	☐ Retired As of ______(YEAR)	☐ On Disability As of ______(YEAR)	

How long have you lived in the San Francisco Bay Area?	☐	Own	☐	Rent
Do you have animals or pets?	☐	Yes	☐	No
If so what kind? ☐ Dog ☐ Cat ☐ Bird ☐ Reptile ☐ Other				
Do you consider yourself religious or spiritual? If so which denomination?	☐	Yes	☐	No
Have you seen doctors or have been treated for nervous disorders?	☐	Yes	☐	No
Are you currently taking or have taken psychological medications or antidepressants?	☐	Yes	☐	No
If so , list:	☐	Presently	☐	Past
Is your partner, spouse, or anyone in your family abusing you or threatening you?	☐	Yes	☐	No

MEN ONLY				
Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Do you feel pain or burning with urination?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam?	Date of last anal pap?			

WOMEN ONLY				
Do you have a current gynecologist?	☐	Yes	☐	No
If so, name.				
Are you pregnant or plan to become pregnant soon?	☐	Yes	☐	No
Are you currently taking birth control?	☐	Yes	☐	No
When was your last pap?	☐	Yes	☐	No
When was your last menstrual period?				
Are your menstrual cycles typically ☐ **Regular** or ☐ **Irregular**?				
Are you prone to yeast infections?	☐	Yes	☐	No
When was your last mammogram?				
Do have currently have pain in your breast or discharge?	☐	Yes	☐	No
If so, describe.				

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COMPLETE THE FOLLOWING **ONLY** IF YOU ARE **HIV+**		
Have you seen an Infectious disease Specialist in the past?	If so, name?	
When was your last negative HIV test, if any?	When did you test positive for HIV?	
Lowest CD4 count?	Highest Viral Load?	Lowest CD4 %
What problems and complications of HIV have you had, if any?		
What are your main concerns regarding HIV?		
List past HIV medications and frequency taken.	1.	2.
3.	4.	5.
6.	7.	8.
9.	10.	11.
12.	13.	14.

CURRENT HISTORY
Have you had any of the following symptoms?

[ ] Fevers	[ ] Headaches	[ ] Shortness Of Breath	[ ] Vaginal Infections
[ ] Night Sweats	[ ] Recurrent Sinus Problems	[ ] Chest Pain	[ ] Numbness/Tingling of Limbs
[ ] Fatigue	[ ] Oral Problem	[ ] Diarrhea	[ ] Loss of Balance
[ ] Unintentional Weight Loss	[ ] Swallowing Problems	[ ] Nausea and Vomiting	[ ] Memory Loss/Confusion
[ ] Swollen Lymph Nodes	[ ] Skin Rashes/Sores	[ ] Urinary Tract Problems	[ ] Decreased Libido/Impotence
[ ] Visual Changes	[ ] Coughing		

PAST MEDICAL HISTORY
Have you ever been diagnosed with any of the following?

Illness	Date	Illness	Date
[ ] Oral Candidacies		[ ] Pneumocystis pneumonia	
[ ] Hairy Leukoplakia		[ ] Bacterial pneumonia	
[ ] Oral Herpes Infections		[ ] Tuberculosis	
[ ] Genital or Rectal Herpes		[ ] Lymphoma	
[ ] Herpes Zoster (shingles)		[ ] Cryptococcus Meningitis	
[ ] CMV Retinitis		[ ] Toxoplasmosis	
[ ] MAI		[ ] Kaposi's Sarcoma	

RECENT LABORATORY VALUES

Please list to the best of your ability your three last blood tests:

Date	Viral Load (PCR or bDNA)	Helper T-Cell Number (CD4)	CD4 %
1.			
2.			
3.			