***Dr. Jean Amoura / Anita Jaynes APRN***

**Please do your best to fill out the following information. Bring to your appointment and give to the medical personnel once in exam room (not the front desk at check in).**

**Legal Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pronouns**: he/him/his \_\_\_ she/her/hers \_\_\_ they/them/their \_\_\_ zie/hir \_\_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My Gender Identity is:** **My Sex assigned at birth is**:

🞎 Cisgender Female 🞎 Female

🞎 Cisgender Male 🞎 Male

🞎 Transgender 🞎 Intersex

🞎 Female to Male 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Male to Female 🞎 Decline

🞎 Nonbinary

🞎 Genderqueer

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My Sexual Orientation is**:

🞎 Asexual 🞎 Queer

🞎 Bisexual 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Gay 🞎 Not Sure

🞎 Heterosexual / Straight 🞎 Don’t Know

🞎 Lesbian

**Current sexual partners**: (*Please check all that apply*)

🞎 Cisgender Men 🞎 Cisgender Women 🞎 Trans Men 🞎 Trans Women 🞎 None 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the past, have your sexual partners been**: *(Please check all that apply)*

🞎 Cisgender Men 🞎 Cisgender Women 🞎 Trans Men 🞎 Trans Women 🞎 None 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Relationship Status**:

🞎 Single 🞎 Separated from spouse/partner

🞎 Married 🞎 Divorced/permanently separated from spouse/partner

🞎 Partnered 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Involved with Multiple Partners

**Living Situation**:

🞎 Live alone 🞎 Live with roommate(s)

🞎 Live with spouse or partner 🞎 Live with parents or other family members

🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you work?**

🞎 Yes – Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 No

🞎 Retired

🞎 Disabled

🞎 Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many years of education have you completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently smoke tobacco**?

🞎 Yes – How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 No

**Do you use any street drugs**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol**?

🞎 Yes – What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 No

**Have you ever been (*Circle all that applies*):**

Physically / Emotionally / Verbally / Sexually……………Abused? \_\_\_\_ In the past \_\_\_\_\_ Currently

Who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please explain the reason why you are coming to this appointment**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you been tested for HIV?**

🞎 Yes 🞎 No

If yes, most recent date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know what PrEP is? 🞎 Yes 🞎 No

If yes, would you be interested in speaking to the pharmacist about PrEP? 🞎 Yes 🞎 No

Have you ever been vaccinated against HPV (Gardasil vaccine)? 🞎 Yes 🞎 No

**Please fill out if it applies to you**:

First day of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any abnormal pap? Yes\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Have you ever been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: Please list any drug allergies or Sensitivities:

**Drug Reaction** **Drug Reaction**

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**Surgical History**: Please list any surgeries or procedures you have had:

**Surgery Year Reason Complications?**

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**Medications**: Please list all medications, vitamins and supplements:

**Drug Dose Reason for taking Taken as prescribed? (Y/N)**

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**Medical History**: Please mark which applies to you:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SELF | Mother | Father | Bro/Sis |  |
|  |  |  |  | Bleeding Disorder |
|  |  |  |  | Blood Clots |
|  |  |  |  | Cancer |
|  |  |  |  | Depression/Anxiety/Mental Health Disorder |
|  |  |  |  | Diabetes |
|  |  |  |  | Heart Disease |
|  |  |  |  | High Cholesterol |
|  |  |  |  | High Blood Pressure |
|  |  |  |  | HIV / AIDS |
|  |  |  |  | Gallbladder Disease |
|  |  |  |  | Kidney Disease |
|  |  |  |  | Liver Disease / Hepatitis |
|  |  |  |  | Polycystic Ovarian Syndrome |
|  |  |  |  | Migraine |
|  |  |  |  | Substance abuse (drugs and/or alcohol) |
|  |  |  |  | Suicide attempt |
|  |  |  |  | MS or other neurologic disorder |
|  |  |  |  | Seizures/epilepsy |
|  |  |  |  | STD’s (chlyamydia, gonorrhea, trichomonas, syphilis, herpes) |
|  |  |  |  | Stroke |
|  |  |  |  | Weight Problems |
|  |  |  |  | Other |
|  |  |  |  |  |

**Transgender History/Intake**: This form should be done in addition to the regular intake form. It tells us more about you as a transgender person and how we can help you. We want you keep you safe and healthy. We will ***NEVER*** penalize you or deny you care based on what you tell us on this form. Please, if you feel uncomfortable answering a question, leave it blank.

At what age did you first feel your gender identity did not match your physical body? \_\_\_\_\_\_\_

Who is your support system? Who do you talk to about your problems (e.g. feeling sad or angry)?

* Significant other 🞎 Family of Origin 🞎 Support group
* Friends 🞎 Therapist 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are the following people supportive of your transition/gender expression?

Employer/School 🞎 no 🞎 yes

Family of origin 🞎 no 🞎 yes

Significant other 🞎 no 🞎 yes

Friends 🞎 no 🞎 yes

Are you out at work/school?

🞎 No one knows 🞎 Some people know 🞎 Everyone knows

If not, would you be safe if you chose to come out? 🞎 no 🞎 yes

What are your fears (if any) about coming out or being transgender?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you changed your gender on your ID’s? 🞎 yes 🞎 no

If no, do you want to? 🞎 yes 🞎 no

Have you ever seen a health care provider about being transgender? 🞎 yes 🞎 no

If yes, when were you first treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who treated you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where are they located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What hormone treatments have you been on, when, and for how long? These can be ones you were prescribed, that you shared with others or that you bought without a prescription. Include any treatment you currently take

**🞎 None** (mark if you have never been on hormones)

**Name of Hormone Dose Start Date How long did you take it for?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had any problems, complications, or other difficulty with hormone treatment?

🞎 yes 🞎 no 🞎 N/A (I’ve never used hormones before)

If you are not currently taking hormone treatment, would you like to?

🞎 yes 🞎 no

If yes, what are you hoping the hormones will do for you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your worries about taking hormone treatment?

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What do you know about the risks/side effects?

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Have you had any gender affirming surgery? 🞎 yes 🞎 no

Do you want to have surgery now or in the future? 🞎 yes 🞎 no

If yes, what kind of surgery would you want? (check all that apply)

🞎 Chest reconstruction (top surgery) 🞎 Breast augmentation (implants)

🞎 Hysterectomy (removal of uterus) 🞎 Orchiectomy (removal of testes)

🞎 Oophorectomy (removal of ovaries) 🞎 Vaginoplasty

🞎 Metoidioplasty 🞎 Tracheal shave

🞎 Phalloplasty 🞎 Facial feminization surgery

🞎 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there anything else you would like to disclose, please use the space below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_