Nebraska Medicine

Dr. Jean Amoura / Megan Smith-Sallans, LIMHP

13 to 18 years Form

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: ________________________________ **Affirmed First Name**: ______________________________

Pronouns: he/him/his ___ she/her/hers ___ they/them/their ___ zie/hir ___ other______________________

Current Gender Identity:

☐ Female
☐ Male
☐ Transgender
  ☐ Female to Male
  ☐ Male to Female
☐ Nonbinary
☐ Genderqueer
☐ Other: ___________________________________

Sex assigned at birth is:

☐ Female
☐ Male
☐ Intersex
☐ Other: ______________________________________
☐ Decline

Sexual Orientation is:

☐ Asexual
☐ Bisexual
☐ Gay
☐ Heterosexual / Straight
☐ Lesbian
☐ Queer
☐ Other: _________________
☐ Not Sure
☐ Don't Know

Who referred you? ____

Family Information:

Living Situation: I currently live with (include all people living in home(s):

Who in the family and extended family is aware of your affirmed gender identity? What is their level of support and acceptance?

Birth History:

Do you know if you were a planned pregnancy? Adopted?

Did your parent use In Vitro Fertilization, Assisted Reproductive Technologies, fertility medications?

During pregnancy, did the person giving birth to you
Experience any traumatic events:____
Take any medications:____
Experience depression, anxiety, stress, etc. ____
Smoke or use alcohol or drugs?____
Were you born on-time, early (how early), late (how late)? Birth weight?
____
Did you have any medical problems at birth? If yes, please describe:
____

Education/Social:

Current School:
Grade in School:
Do you currently receive any special education services?
Is your school aware of your affirmed gender?
What bathroom/locker room are you currently using at school?

Have you socially transitioned (e.g., changed name/pronoun, clothing, hair, etc.) at school and if so what has your experience been?
Have you experienced any bullying/harassment at school? If so, what has been the effect on you? Is the school aware and if so, what has been their response?

Mental Health:

Have you experienced any of the following abuses? (*Check all that apply*):

Physical   Emotional   Verbal   Sexual   *When?* In the past   Currently

Have you seen a therapist (currently or in the past)? Please list therapist's name, length of treatment and how often seen, reasons for initial visit, goals of therapy:

Have you been hospitalized for a psychiatric condition? If so, please give reason for hospitalization, dates and last hospitalization or partial care:

Please complete checklist below. If you are unsure, leave blank:

Self	Parent	Parent	Sibling	
				Anxiety (including social and separation)
				Attention Deficit Hyperactivity Disorder (ADD, ADHD)
				Autism Spectrum Disorder
				Bipolar Disorder
				Depression
				Developmental Delays
				Eating Disorder or other Eating Issues (describe type below)
				Learning Disability (describe type below)
				Intellectual Disability (describe type below)
				Obsessive Compulsive Disorder
				Conduct Problems
				Trauma History/Symptoms (please describe below)
				Substance Use/Dependence (please list substances below)
				Suicide Attempt(s)
				Suicidal Thoughts
				Psychiatric Hospitalization
				Psychiatric Treatment
				Hearing Voices/Seeing Things
				Self-Harm (please describe type and method below)
				Sleeping Issues (insomnia, nightmares, etc.)
				Phobias (please describe type below)
				Attachment Issues
				Other (please describe below)

Please provide brief details of any of the boxes you checked or tell us about any issues you are experiencing that were not listed. You will be able to discuss any and all concerns during your visit.

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

Medical History

Allergies: Please list any drug allergies or sensitivities

Drug	Reaction	Drug	Reaction

Surgical History: Please list any surgeries or procedures you've had:

Surgery	Year	Reason	Complications?

Medications: Please list all medications, vitamins and supplements:

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

Medical History: Please mark which applies to you:

Self	Parent	Parent	Sibling	
				Bleeding Disorder
				Blood Clots
				Cancer
				Toileting Issues
				Diabetes
				Heart Disease
				High Cholesterol
				High Blood Pressure
				HIV / AIDS
				Gallbladder Disease
				Kidney Disease
				Liver Disease / Hepatitis
				Polycystic Ovarian Syndrome
				Migraine
				MS or other neurologic disorder

				Seizures/epilepsy
				STD's (chlyamydia, gonorrhea, trichomonas, syphilis, herpes)
				Stroke
				Weight Problems
				Other
				Other
				Other
				Other

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

When did you first become aware of your affirmed gender identity?

Please describe your current gender presentation?

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

- ☐ School Personnel
- ☐ Family of Origin
- ☐ Support group
- ☐ Friends
- ☐ Therapist
- ☐ Other: ____________________

Do you have any concerns about your safety regarding your gender identity/expression?

Does your primary care doctor know about your gender identity? ☐ yes ☐ no

What are your worries about cross sex hormones?

Do you have any worries about the risks/side effects of cross sex hormones?

What are you excited about/looking forward to regarding cross sex hormones?

Do you have a desire to have surgery in the future? ☐ yes ☐ no
If yes, what kind of surgery are you interested in? (check all that apply)

☐ Chest reconstruction (top surgery)
☐ Hysterectomy (removal of uterus)
☐ Oophorectomy (removal of ovaries)
☐ Metoidioplasty
☐ Phalloplasty
☐ Breast augmentation (implants)
☐ Orchiectomy (removal of testes)
☐ Vaginoplasty
☐ Tracheal shave
☐ Facial feminization surgery

Other:____

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