Patient Intake Form

We'd like to welcome you as a new patient! Please take the time to fill out this form as accurately as possible so we can give you the best service. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

We will ask you questions about your race, gender identity, sexual orientation, and health. We do this because we want to know and assist you as a person, and believe that your identities are important and vital to your health.

TO NOTE: While this clinic recognizes and advocates for all gender identities, many insurance companies and legal entities do not. Please understand that the legal name and sex at birth listed on your insurance must be used on documents pertaining to insurance and billing. If your name and pronouns are different from these, please mark the box below so we know your name and pronouns. Our staff are trained to make your visit here as comfortable and respectful as possible, and we will use the name and pronoun you list on this form.

- ❏ **MY NAME AND PRONOUNS ARE DIFFERENT THAN THE ONES LISTED ON MY LEGAL DOCUMENTS.**

Full Name: ___________________________
(The name you go by)

Pronouns: ____________________________

Legal Full Name: ______________________
(The name listed on your birth certificate and identifying documents)

What is your current gender identity? (Check all that apply)

- ❏ Male
- ❏ Female
- ❏ TransMale/Transman
- ❏ TransFemale/Transwoman
- ❏ Genderqueer
- ❏ Another gender (Please Specify): _______________

Age: _________________________________

Date of Birth: _________________________

Race/Ethnicity Identity:______________________________

What sex were you assigned at birth?

- ❏ Male
- ❏ Female
- ❏ Decline to State

Medical History

Please check all that apply.

___ Emphysema	___ Hepatitis B
___ Tuberculosis	___ Hepatitis C
___ Pneumonia	___ Cirrhosis
___ Bronchitis	___ Anemia
___ Asthma	___ Thyroid Trouble
___ Allergies	___ Gallbladder Disease
___ Heart Disease	___ Ulcers
___ Stroke	___ Frequent Urinary Tract Infections
___ High Blood Pressure	___ Living with HIV
___ Elevated Cholesterol	___ Sexually Transmitted Infections
___ Diabetes	___ Prostate Trouble
___ Venous Thrombosis	___ Cancer
___ Hepatitis A	___ Arthritis
___ Fractures	___ Osteoporosis
___ Migraines	___ Anxiety or Panic Disorder
___ Depression	___ Posttraumatic Stress Disorder
___ Alcohol or Substance Use Problem	Other: ___________________________

Systems Review

Please check any of the following symptoms that you have recently experienced or are a concern to you.

General:

___recent weight loss
___recent weight gain
___fatigue
___fever
___changes in appetite
___night sweats

Skin:

___rashes
___lumps
___itching
___dryness
___color change
___hair or nail change

Head:

___headaches
___head injuries
___dizziness

Mouth & Throat:

Date of last dental exam: ___/___/___
___bleeding gums
___frequent sore throats
___hoarseness

Respiratory:

___cough
___wheezing
___shortness of breath
___coughing up blood

Eyes:

Date of last exam: ___/___/___
___glasses
___contacts
___pain
___double vision
___redness
___glaucoma
___cataracts

Nose:

___frequent colds
___nasal stuffiness
___hay fever
___nosebleeds
___sinus trouble
___dust/animal allergies

Ears:

___hearing loss

Neck:

___goiter
___lumps/swollen glands
___pain

Breasts:

Date of last mammogram: ___/___/___
___lumps
___pain
___nipple discharge

Cardiac:
___heart murmur
___chest pain
___palpitations
___swelling of feet
___shortness of breath

Urinary:
___frequent urination
___painful urination
___blood in urine
___stones
___difficulty urinating or difficulty holding urination
___waking up to go to the bathroom several times at night

Peripheral Vascular:
___leg cramps while walking
___varicose veins
___thrombophlebitis

Psychiatric/Psychological:
___anxiety
___depression
___phobias
___family problems
___eating disorder

Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?
___Yes, in the past year
___Yes, prior to this past year
___No

Gastrointestinal:
___trouble swallowing
___heartburn or gas
___nausea
___vomiting
___rectal bleeding
___constipation
___diarrhea
___abdominal pain
___hemorrhoids
___jaundice (skin or whites of eyes turning yellow)

Musculoskeletal:
___joint stiffness
___arthritis
___gout
___backache
___muscle pains
___muscle cramps

Neurological:
___fainting
___blackouts
___seizures
___weakness
___numbness
___tremors
___tingling hands or feet
___change in memory

Has anyone ever forced you into having any type of sexual activity?
___Yes
___No

Hematologic:
___anemia
___easy bruising or bleeding
___blood transfusions: Year(s) _________

Endocrine:
___heat or cold intolerance
___excessive sweating
___excessive hunger
___excessive urinating

Do you experience chronic pain?
___Yes
___No

If YES, how is your pain managed (ie, physical therapy, medication, etc)?

____
____

On a scale of zero to ten, with ten being the worst and zero being no pain, how would you rate your current pain?

_____

Operations and/or Hospitalizations: (Please list surgeries and/or hospitalization reasons and dates)

____
____
____

Current Medications: (Please include any non-prescription drugs as well, eg, vitamins, aspirin, etc.). If you need more room, please use the back of this form.

Medication Name	**Dose**	**Frequency of Use**
1. ____________________	____________________	____________________
2. ____________________	____________________	____________________
3. ____________________	____________________	____________________

Allergies: (Please list any allergies you may have to medications and food)

____

Family Medical History
Please check all that apply.
___ Stroke
___ Heart Disease
___ High Blood Pressure
___ Thyroid Disease
___ Kidney Disease
___ Diabetes
___ Arthritis
___ Osteoporosis
___ Migraine Headaches
___ Alcoholism
___ Asthma
___ Depression
___ Anxiety
___ Cancer/Type(s): ________________________________

Vaccinations/Prevention

Date of Last Tetanus Vaccination: ___/___/ _______

Have you received any of the following vaccines:
Hepatitis A?
___Yes
___No
___Not Sure

Hepatitis B?
___Yes
___No
___Not Sure

Pneumo vax?
___Yes
___No
___Not Sure

Have you had a blood test for Rubella (German Measles)?
___Yes
___No
___Not Sure

Date of Last Colonoscopy:
___/___/____
___ Check here if not applicable

How often do you wear seatbelts?

____

Are there any firearms kept in your home?
___Yes
___No

Does someone have power of attorney or healthcare proxy giving them the power to make decisions about your care in life-threatening situations?
___No
Yes: (name of person and their relationship to you)

____

Do you have an advanced health directive, such as do not resuscitate?
___Yes
___No

Gender Identity

We encourage you to talk to your doctor about any questions, concerns, or comments you have, if any, about your gender or gender identity (sense of your femaleness/maleness). Please list any questions, concerns, or comments that you might have about your gender identity here.

____
____
____
____
____
____

Sexual Orientation & Sexual History

How do you identify in terms of sexual orientation?
____

Are you attracted to (check all that apply):
___Men
___Women
___Transgender Men
___Transgender Women

Have you had sex with (check all that apply):
___Men
___Women
___Transgender Men
___Transgender Women

When you have sex, do you have (check all that apply):
___Oral Sex
___Vaginal or Front Hole Sex
___Anal Sex

How often do you use condoms when having:
Oral Sex: ______________________
Vaginal or Front Hole Sex: ____________________
Anal Sex: _______________________

When is the last time you had sex without using a condom?
____

Do you have a primary (main) sexual partner?
Yes
No
I have more than one primary partner

If you selected yes or that you have more than one primary partner, is your primary relationship(s) open? Meaning, do you and your primary partner(s) have an agreement that you can have sex with people outside your primary partnership(s)?
Yes

No

Do you have any casual sexual partners?
Yes
No

When was the last time you were tested for HIV?
____

What were the results? ____________________

Please check any of the following infections that you have had:
___Syphilis
___Gonorrhea
___Pelvic Inflammatory Disease
___Herpes
___Trichomonas
___Genital Warts
___ Yeast Infections
___Chlamydia
___Crabs
___ Bacterial Vaginosis

For each of the above that you checked, please note:
1) when the infection was
2) if you completed treatment
3) if your partner(s) were informed
4) if you need help telling your partners.

1) ________________ 2) __________ 3) __________ 4) __________
1) ________________ 2) __________ 3) __________ 4) __________
1) ________________ 2) __________ 3) __________ 4) __________
1) ________________ 2) __________ 3) __________ 4) __________

Do you know or believe that any of your partners have had HIV or another sexually transmitted infection?
Yes
No
I’m not sure

Have your current partners been tested for HIV and other sexually transmitted infections?
Yes
No
I’m not sure

If yes, what were the results? ______________________

Are you satisfied with your sexual life?
Yes
No
I’m not sure
Not applicable

Please describe any sexual concerns you may have:
____
____
____
____
____
____

Gynecologic History

If not applicable due to sex and/or gender, please check here ___ and skip to Hormones section

Age of First Period: ___

Date of Last Pap: ___/___/___
Results:
___Normal
___Abnormal

Have you ever had:
An abnormal Pap?
Yes
No

Ovarian Cysts?
Yes
No

Fibroids?
Yes
No

DES Exposure? (DES is a synthetic form of estrogen. It was prescribed to pregnant women between 1940 and 1971 to prevent miscarriage, premature labor, and related complications of pregnancy).
Yes
No

Have you had a hysterectomy?
Yes
No

If YES: Why was it performed? ____

Were your ovaries removed?
Yes, both
Yes, one
No

If menopausal/postmenopausal, please check here ___ and skip to below the dotted line.

Date of Last Period: ___/___/___
Frequency of Periods: (eg, every 28 days) ______

Average Length of Period:
___days

Bleeding:
___Light
___Moderate
___Heavy

Other Bleeding:
___No
___Yes, between periods
___Yes, after penetrative sexual activity

Do you experience any of the following symptoms with your period?
Check all that apply.
___Headaches
___Weight Gain
___Swelling
___Cramps
___Anxiety
___Depression
___Other: ________________________________

Are you currently using birth control?
___Yes
___No

If YES: Which type of birth control are you using (Check all that apply):
___Pills
___IUD
___Condoms
___Foam
___Foam & Condoms
___Patch
___Diaphragm
___Ring
___Depo
___Tubal Ligation
___Vasectomy
___Other: _______________________________________

Have you ever taken birth control pills?
Yes, for __________(how long?)
No

Are you currently pregnant or planning to become pregnant?

Yes
No

If you have not begun menopause, please check here ___ and continue to the next section.

Age at menopause: ___

Have you ever taken estrogen replacement? (Not for gender identity purposes).
Yes
No

If YES: What was the name of the estrogen replacement?
____

Age when estrogen replacement was started: _____

How long was estrogen replacement used? _____

What was your estrogen dose? ___________

Have you ever taken progesterone? (Not for gender identity purposes)
Yes
No

If YES: How many days per month? ____

How long was progesterone replacement used? _____

What was your progesterone dose? ___________

Please check any of the following symptoms of menopause you are having:
___ Hot Flashes
___Fatigue
___Anxiety
___Depression
___Insomnia
___Irregular Bleeding
___Vaginal / Front hole Burning/Itching

___Vaginal / Front hole Dryness
___Pain during Vaginal / Front hole Penetration
Other: ____________________

Obstetric History

How many times have you been pregnant?

_____

How many miscarriages have you had?

_____

How many pregnancy terminations have you had?

_____

How many vaginal or front hole deliveries have you had?

_____

How many caesarean sections have you had?

_____

Have you had any ectopic pregnancies?
Yes
No

Have you had gestational diabetes?
Yes
No

Do you have a history of infertility?
Yes
No

Hormones for Gender Identity Purposes

If not applicable, please check here ___ and skip to the next section.

Are you currently taking hormones for gender identity purposes?
Yes

No

If YES: How long have you been taking them? _____________

What hormones are you taking? ____

Have you ever used hormones for gender identity purposes in the past?
Yes
No

If YES to past or current hormone use, what types of complications, if any, have you experienced?

____
____
____
____

What types, if any, of gender confirmation surgery have you had?

____
____
____

What types, if any, of other gender identity procedures have you had?

____
____
____

What types of complications, if any, have you experienced following such surgeries and/or procedures?

____
____
____
____

What concerns or questions, if any, do you have regarding gender identity and gender confirmation surgeries or procedures?

____
____

____
____

Lifestyle & Health Habits

Do you follow a special diet?
Yes
No

If YES, please check appropriately:
___Vegetarian
___Vegan
___Low Fat
___Low Carb
___High Fiber
___Calorie Restriction
Other: _______________________________

Have you ever binged, purged, or restricted your food intake?
___No
___Yes

What concerns, if any, do you have about your eating practices?
____
____
____

How often do you exercise at a moderate or vigorous level for 30 minutes or more?
____

What type of exercise(s) and/or sports do you engage in?
____
____
____
____

On a typical day, how many cups of caffeine containing beverages (coffee, tea, soda, energy drinks, etc) do you have?

_____

On a typical day, how many portions of calcium enriched food do you eat? _____
(Examples of portions = one cup of milk, one slice of cheese, one cup yogurt,1/2 cup of ice cream)

On a daily basis, how much calcium do you consume through tablets or chews?
___<500 mg
___600-1200 mg
___Not Sure

Substance Use History

How many drinks containing alcohol do you have, on average, per week?
____

Have you ever been concerned about your drinking?
Yes
No
Not Sure
Has anyone, including a family member, friend, or healthcare worker been concerned about your drinking or suggest you cut down?
Yes
No
I’m not sure

How many cigarettes do you smoke per day? _______

How old were you when you first started smoking? ____

Have you ever tried to quit smoking?
Yes
No
NA

Are you interested in quitting smoking?
Yes
No
NA

If you are a former smoker, how long ago did you quit?

____

Please check any of the substances listed below that you have used, even if it was only once:

___ Marijuana
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________

___Cocaine
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________
How do/did you use it (ie, smoke, inject, sniff)? ___________________

___Crystal Meth
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________
How do/did you use it (ie, smoke, inject, etc)? _____________________

___Heroin
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________
How do/did you use it (ie, smoke, inject, etc)? _____________________

___Other Opiates (oxycontin, vicodin, percodan, etc)
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________
How do/did you use it (ie, orally, smoke, inject, etc)? _________________

___Ecstasy/Mushrooms/LSD
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________

Other Substance(s): ____
When was the last time you used it? ____________________________
How frequently do you/did you use it? __________________________
How do/did you use it (ie smoke, inject, etc)? ______________________

Have you ever injected any type of substance?

Yes
No

Did you ever share your needle, cooker, cotton, rinse water, or any other part of your set?
Yes
No
I’m not sure

What types of problems has drug use caused for you (ie, relationships with others, problems at work, depression, anxiety, physical health, etc)?
____
____
____
____

What concerns, if any, do you have about either your past or current drug use?
____
____
____
____

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care of you.