



MEDICAL INTAKE FORM

Date:

Reason for Consultation:

Name I wish to be called: Legal Name:

Date of Birth: / / Age:

Have you legally changed your name? Yes No If yes, when was the date:

Have you changed your gender on your IDs? Yes No

How do you identify?

- woman man transgender woman transgender man non-conforming genderqueer decline

Who is your support system?

- significant other family friends therapist support group

When did you start hormones? Have you started hair removal (vulvo/vaginoplasty patients only)? Yes No

If yes, how many sessions have you completed?

Have you obtained the necessary assessment letters from a medical or mental health provider? Yes No

- Required letters:** ONE hormone therapy letter documenting 12 months or more on hormones TWO mental health letters from two separate mental health providers (qualified mental health providers with a doctoral or master’s level degree; PhD, MD, PsyD, LCSW, MSW, MFT, DSW, APRN, NP, LPC)

Alcohol/Tobacco/Recreational drug use:

Current Recreational drugs: Yes No

If yes, what type and how often:

Prior history of recreational drug use: Yes No

If yes, what type: When did you start and quit?

Current Cigarettes: Yes No

If yes, packs per day: Cigarettes per day:

Prior history of cigarette/tobacco use: Yes No

If yes, packs/cigarettes per day: When did you start and quit?.....

Current Inhalational drugs (vaping, marijuana, cigars, etc.): Yes No

If yes, what kind and how much:

Current Alcohol use: Yes No

If yes, how much:

Medical History: (Please complete ALL applicable fields)

Height: (ft/in.)

Weight: (lbs.)

Waist circumference: (cm)

Have you ever felt suicidal or attempted suicide? Yes No

Do you currently have a mental health provider you see regularly? Yes No

Hysterectomy consults only: Date of last pap smear: History of abnormal pap smear: Yes No
Patient Name: **Date of Birth:** / /

Please indicate what medical problems you have now or have had in the past:

Past	Present	Medical Problem	Comments/Approximate Dates
		Heart Disease	
		High Blood Pressure	
		Diabetes	
		Anemia	
		HIV or AIDS	
		HEP B or HEP C	
		Liver Disease	
		Kidney Disease	
		Thyroid Problems	
		Cancer	
		Stroke	
		COPD	
		Asthma	
		Depression	
		Anxiety	
		Other	

Do you bruise easily or have any bleeding or blood clotting problems? Yes No
 Do you have a history of hypertrophic scarring or keloids? Yes No

What medications do you take (including hormone therapy, vitamins, supplements, other)? Please provide the name, dosage, and directions (pill, injection, etc.). Please indicate what the medication is for.

Medication Name	Dosage	Directions	What is it for?

What operations have you had in the past? (Please do not input future surgery dates)

Surgery Type	Date	Name of Surgeon

Have you or a relative ever had a bad reaction to general or local anesthesia? Yes No

If yes, what was the reaction? Who had the reaction?

Are you allergic to latex? Yes No Are you allergic to shellfish? Yes No

Are you allergic to any medications? Yes No If yes, please list below:

Medication Name: Reaction:

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