Name You Wish Us to Use:	**Pronouns You Wish Us to Use**
Gender Identity:	**Sexual Orientation**:

This form represents information we are interested in to get to know you better and well as topics of discussion during your visits. It is helpful if you complete this prior to your visit but feel that you can leave any part blank and we can discuss 1:1.

What would you like to focus on during today's visit?

Medical History

What health problems (medical or mental health) do you have (or have had)? Include conditions you have received medications for or require ongoing healthcare.

Health Condition	Treatment	Care Provider

Do you have menstrual cycles? □ No □ Yes, date bleeding last started _____

What surgeries have you had for any type of reason?

Medications

List medications and supplements you are currently taking.

Medication	**Dose** (if you know)	**Reason for Taking**

Allergies

List any medication or other allergies you have and describe the reaction you have had.

Substance Use

Tobacco use: cigs/day _____ vaping/day _____ smokeless/day _____
□ date last used _____ □ never used tobacco products

Alcohol use: drinks/week _____ □ date last used _____ □ never used alcohol

Drug use:
Marijuana amount/frequency _____
Crystal/methamphetamine/amphetamines amount/frequency _____
Cocaine amount/frequency _____
Opiates/Heroin/hallucinogens amount/frequency _____
Other _____ amount/frequency _____
□ last date used _____ □ never used drugs

Do you use tobacco/alcohol/drugs to cope with any of the reasons you are today?
□ Yes □ No

Health Screenings

Health screening tests you have had: □ pap smear □ cholesterol □ blood sugar
□ colon cancer □ breast cancer □ prostate cancer □ sexually transmitted infections

Have you had routine childhood immunizations □ Yes □ No
Specifically, have you had vaccines for: □ HPV (human papilloma virus) □ This year's Flu

Your Family and Support Systems

Families play an important role in our life experiences. Everyone has family but it may not always be in the traditional form. Our family may include those we are related to by blood, those we share resources with, and those we provide and receive support from. We are interested in learning about your family, in whatever form that takes.

Family Health History

The health of the people you are related to impacts your health and wellbeing. Tell us about any health problems your parents, grandparents, siblings and your children have.

□ I am adopted □ I don't know my relative's health histories

Parents:
Grandparents:
Siblings:
Children:

Family Building

Do you have children? □ No □ Yes

What are your thoughts about having children or parenting in the future?

Relationships and Support System

Tell us about your current living situation? □ Live alone □ Homeless
□ Live in temporary housing □ Live with parent(s)/sibling(s) □ Live with roommate(s)
□ Live with children □ Other _____

Are you happy/comfortable with your current living situation? □ No □ Yes

Who are the major support persons in your life?

Does a community, culture, and/or faith practice play a role in your life? If so, can you tell us about that?

Physical Activity

What kinds of physical activity do you incorporate into your daily life?

Nutrition

Describe your typical diet including any specific nutrition plan you follow or dietary restrictions.

How do you feel about your weight?

Do you experience any difficulties securing food/meals?

Body Relationship

Body image is the relationship you have with your body – it encompasses your thoughts, feelings and perceptions as well as actions pertaining to your physical appearance.

What things feel good about your body?

What feelings about the way you look often get in the way of accepting yourself and enjoying your life?

Are there aspects of your physical appearance that you really dislike?

Is there something you would like to change about your physical appearance?

Do you avoid activities, situations, relationships because you feel physically self-conscious?

Sleep

Do you normally wake up feeling rested? □ Most of the time □ Sometimes □ Never

Work and School

Are you working and/or going to school? □ Yes □ No

If yes, what do you do for work?

If yes, where are you going to school?

Relaxation and Fun

How do you make time for fun and relaxation in your life?

Managing Safety and Stress

What people and in what situations do you feel most safe and stress-free?

Tell us about any situations or people that make you feel unsafe and stressed.

Have you had experiences that are difficult to deal with?

Depression and Anxiety Assessments

Over the last two weeks, how often have you been bothered by any of the following problems? Circle the number to indicate your answer.

Statement	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed or hopeless.	0	1	2	3
Trouble falling/staying asleep or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV.	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
Feeling nervous, anxious, or on edge.	0	1	2	3
Not being able to stop or control worrying.	0	1	2	3
Worrying too much about different things.	0	1	2	3
Trouble relaxing.	0	1	2	3
Being so restless that it's hard to sit still.	0	1	2	3
Becoming easily annoyed or irritable.	0	1	2	3
Feeling afraid as if something awful might happen.	0	1	2	3
If you identified any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult

Sexuality

Healthy sexuality is the ability to embrace and enjoy our sexuality throughout our lives.

Do you feel good about how you experience your sexuality in the ways you identify, express yourself, find pleasure, feel safe, and connect with others?

Is there anything you would like to change or experience differently?

What questions or concerns do you have: □ Interest/desire □ Arousal/erections/being turned on □ Orgasms/ejaculation □ Pain

Are you sexually active (sex defined as erotic stimulation – mental or physical – that is solo or partnered, to cause pleasure)? □ Yes □ Not currently □ Never been sexually active

Sexual Partners

Describe your current sexual relationship: □ Not in a relationship □ Casual □ Partnered, open relationship □ Partnered, monogamous □ Married, open □ Married, monogamous □ Other _____

Sexual partners identity as: □ Men □ Women □ Transgender/Gender diverse

Number of sexual partners in last year: _____

Sexual Experiences

What things are part of your sexual experiences: □ BDSM/Kink □ Anal sex □ Manual stimulation/fingering □ Masturbation □ Oral sex □ Toys □ Vaginal sex

Do you ever have the need to for a birth control method to help you or your partners prevent pregnancy? □ No □ Yes, I use _____

□ Yes, I would like more information on options.

What steps do you take to protect yourself and your partners from sexually transmitted infections?

Unwanted sexual experiences: □ Yes □ No

Gender

Do you feel good about how you experience your gender in the ways you identify, express yourself, find pleasure, feel safe, and connect with others?

Is there anything you would like to change or experience differently?

If you are seeking Gender Medicine services, please complete the remainder of this form.

Gender Development

1 in 100 babies are born with bodies that are different from what is considered typical for male or female bodies.

Was this your experience? □ Yes □ No

What was your earliest memory that how you experience your gender is different from your physical body?

What was your experience of your gender and your body during puberty?

Gender Experience

What was your experience like coming out to yourself?

What was your experience like coming out to your friends?

What was your experience like coming out to your family?

What was your experience like coming out at work, school, a faith-based community, and/or social networks?

Tell us about any problems because of discrimination due to your sexual orientation and/or gender identity you have experienced.

Gender Affirming Care and Coping

Are you involved in LGBTQ communities?

Are you considering changing your physical appearance? □ Yes □ No

What changes have you considered? □ Diet □ Exercise □ Hormones □ Binding/Tucking/Packing □ Silicone □ Chest/Breast Surgery □ Facial Feminization □ Bottom Surgery □ Other _____

What changes have you made? □ Diet □ Exercise □ Hormones □ Binding/Tucking/Packing □ Silicone □ Chest/Breast Surgery □ Facial Feminization □ Bottom Surgery □ Other _____

Tell us the story about your name.