Robert Eads Health Project
Medical History Initial Visit

Date ___/___/___

Legal Name ____________________________________ Preferred Name (if different): ____________________________
Date of Birth ___/___/___Age _____ Gender _____________ Appropriate Pronoun(s): He/him Ze/hir She/her
Address ____ Apt # ________ Phone (h) (___) ______-___________
City __________________________ State ___________________ Zip ___________ (w/c) (___) ______-____________
Which number should we use? __________________________ What is the best time to call? _______________________
Is it okay to leave messages for you? ____
Emergency Contact: Name ____ Relation to this person__________________
Address ____ Apt # _______ Phone (h) (___) ______-____________
City __________________________ State _____________________ Zip ___________ (w) (___) _____-____________
In the event that this person is contacted, is there any information that you would not like to be disclosed?_____________
____
Years of education ______________ Language you speak: English, Spanish, other__________________________________
Can you read/ understand English to fill out this form? yes ( ) no ( )
If not speaking English, Interpreter's name____
Pharmacy name and # ____Religion _____________________
DRUG ALLERGIES ____
CURRENT MEDICATIONS (including testosterone) ____
____

Hormone Therapy

1. Are you currently taking testosterone? yes ( ) no ( )
   Testosterone start date ____/____/____
   Have you ever stopped taking testosterone? yes ( ) no ( )
   If so, when and for how long? ______________________
   Form of testosterone? (IM injection of Cypionate / Ethanate, Androderm, Androgel, herbal, other) _______________________________
   Current dosage ____ml/______days
2. Has a physician prescribed testosterone for you? yes ( ) no ( )
3. Are your T levels and other blood counts being periodically checked by a physician?
   yes ( ) no ( ) if yes, how often? _____________________
4. Have you experienced any adverse reactions to testosterone? yes ( ) no ( )
   If yes, please explain ____

Surgical History

5. Have you had any of the following surgical procedures? (Circle all that apply.)
   FTM Chest Reconstruction Mastectomy Liposuction/Chest Reduction
   Metoidioplasty Phalloplasty Centurion Scrotoplasty Vaginectomy
   Urethroplasty Testicular Prostheses Hysterectomy Oophorectomy Other Liposucion
   Other related surgery _________________________Date of surgery:_________________
6. Please comment on any complications/problems/adverse reactions due to these procedures:
   ____
   ____

Sexual History/ Information This information helps us with your care.

7. Currently in sexual relationship Yes ( ) No ( )

Please indicate any sexual behaviors you have participated in, and describe what body parts or toys you have used in the sexual behavior. For example, if you have had receptive anal sex (your anus is penetrated), please write in the blank what object penetrated your anus (for example, the penis, finger, tongue, or toys used by another person).

( ) receptive anal sex (your anus is penetrated) __________________________________
____

Comments- Staff Only

( ) receptive frontal hole / vaginal sex (your frontal hole is penetrated) _______________
____
( ) active anal sex (you penetrate another's anus/rectum) ___________________________
____
( ) active frontal hole / vaginal sex (you penetrate another's vagina/frontal hole) _______
____
( ) receptive oral sex (you receive from someone else's mouth) ______________________
( ) active oral sex (you use your mouth on someone else) _______________________
Do you currently have more than one sexual partner? Yes ( ) No ( )
# of partners in last year _____ Do you practice safer sex? Always( ) Sometimes ( ) No ( )
Need information on safer sex? Yes ( ) No ( )
Partner's History (Circle all that apply.)
Has other partners Is a hemophiliac HIV +/ AIDS Use street drugs

8. ____ Check if you wish to receive birth control information.

Social History

Write out "YES" or "NO" to the following, indicating your recent experience.

9. ____ Death of family member/ friend
10. ____ Emotional/ relationship problems
11. ____ Job loss/ financial problems
12. ____ Problem in living arrangement/ school
13. ____ Legal problems/ arrests/ divorce
14. ____ Parental problems
15. ____ Has anyone forced you to have sex?
16. ____ Are you afraid of your partner/ family member?
17. ____ Do you smoke? How many cigarettes a day? ____
18. ____ Do you drink? How much alcohol do you consume per week? ____
19. ____ Do alcohol/ drugs cause problems in your life?
20. ____ History of emotional/ mental illness?
21. ____ Do you feel you are in an abusive relationship?
22. ____ Do you feel you need to speak to a counselor of any kind?
23. ____ Do you use street drugs? What kind? _________ Date of last use ______
24. Who helps and supports you with problems? ____________
25. Who do you live with? Family Friends/Roommate Partner I live alone Other __________

Pregnancy (OB) History

Complete below:

26. Have you ever been pregnant? Yes ( ) No ( ) **If NO, skip to next section.**
    Total no. of pregnancies _________ Living children ________
    Live births _____ Miscarriages _____ Abortions _____ other _____
    # of C-sections __________ Date of last pregnancy __________
    Problems with pregnancies (high blood pressure, seizures, toxemia, gestational
    Diabetes, birth defects) other _________________________
27. Please elaborate on any additional OB information that you would like us to know____
    ____

Personal Medical History

Write out "YES" or "NO" to the following and circle items that apply (current and past).

28. ____ Eye/ vision problems, glasses/ contacts
29. ____ Deaf/ mute. Do you know sign language? Yes ( ) No ( )
30. ____ Heart problems/ murmurs/ surgery/ MVP (mitral valve prolapse)
31. ____ High Blood Pressure
32. ____ Strokes/ Blood Clots in head, heart, brain, brain/head injury?
33. ____ Varicose veins
34. ____ High cholesterol/ blood fats

Comments- Staff Only

35. ____ Diabetes/ High sugar (insulin/ diet/ oral)
36. ____ Bladder/ kidney problems/ infections
37. ____ Headaches/ migraines/ stress related or other
38. ____ Seizures/ epilepsy
39. ____ Thyroid conditions/ medications
40. ____ Liver disease/ Hepatitis
41. ____ Stomach problems/ gastritis/ ulcers
42. ____ Bowel problems/ Colitis/ Irritable bowel/ Crohns
43. ____ Lung problems/ Disease/ Asthma
44. ____ Anemia/ Low iron/ Sickle Cell/ Thalassemias/ Blood diseases/Polycythemia Vera
45. ____ Gallbladder disease/ surgery
46. ____ Cancer
47. ____ Numbness in legs or arms
48. ____ Are you currently under care for a problem/ illness by a health care professional? Explain ____

____

49. ____ Have you ever been hospitalized (except childbirth or SRS related surgery)? Explain____

____

50. ____Has a medical professional ever described your sexual anatomy/hormones/ chromosomes as intersexed, or as a disorder of sexual development? If yes, please explain: ____

____

51. ____ Received blood products before 1978?
52. ____ Do you have needle anxiety? with finger pricks?
53. ____ Ever react to ANY DRUG/ MEDICATION/ FOOD/ including local anesthesia, shellfish, Iodine, metals, latex ____
54. ____ Immunizations up to date? Last tetanus: _____________
Rubella vaccination: Y N Hepatitis B: Y N HPV Vaccine: Y N
55. ____ Do you use herbs/ vitamins/ or complimentary therapies?

Top/Lower History

Write out "YES" or "NO" or "N/A" to the following and circle items that apply.

56. ____ Is this your first pelvic exam? If not, date of last exam ______________________
Comments about previous exam or concerns about this exam (if applicable):____
____
57. ____ Chest disease or non-trans related top surgery
58. ____ Nipple discharge/ leaking
59. ____ Mammogram
60. ____ Lower infections/ itching/ burning
61. ____ Pain/ bumps/ swelling/ sores
62. Sexually transmitted diseases: circle all that apply.

Herpes Warts/HPV Chlamydia/ LGV Gonorrhea Trichomonas

Syphilis HIV/AIDS Hepatitis B Group B Streptococcal Infection

63. ____ Pelvic inflammatory disease (PID) Date _____
Treatment: ____
64. ____ Endometriosis/ uterine fibroids
65. ____ Cysts on ovaries/ Polycystic Ovarian Syndrome
66. ____ Abnormal pap (date) ____________
67. ____ Bleeding and/or pain with sex
68. ____ Did your mother take medications to prevent miscarriage when pregnant with you? DES ( ) Other ( )

Comments- Staff Only

Menstrual History

Write out "YES" or "NO" or “N/A” to the following and circle items that apply.

69. Age bleeding/menstruation began _______
70. ____ Have testosterone treatments effectively stopped your bleeding?
    If no, please explain any complications ________________________________
71. If you are not currently taking testosterone, please answer the following questions:
    Are your cycles regular? yes ( ) no ( ) sometimes ( )
    # days in each cycle: _______ # days you bleed _______
    ____ Cramps / pain / bloating / depression
    ____ Do you use medications/ herbs/ other ________ for relief?
    ____ Bleed between cycles?
    ____ Menopausal/ perimenopausal
    ____ First day of last period ____/____/____ Normal ( ) Abnormal ( )

Comments- Staff Only

Family History Adopted: yes ( ) no ( )

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles.

72. ____ Diabetes ____
73. ____ Heart attack before age 50 ____
74. ____ High Blood Pressure ____
75. ____ Cancer (breast, ovarian, uterus) ______________________________________
76. ____ Osteoporosis ____
77. ____ High cholesterol ____
78. ____ Alcoholism/ addictions/ mental illness _________________________________
79. ____ Birth defects/ genetic illness ____

80. Please indicate in the space provided below any medical information you wish to disclose or any further explanations of medical information that was not covered in history form:

____
____
____
____
____
____
____

Client signature ____ Date: ______________ Updated: __________

Interviewer signature ____ Date: ______________ Updated: __________

RN/APN Review____ Date: ______________ Updated: __________

MD Review ____Date: ______________ Updated: __________

*This information is confidential and will not be released without your written permission.

Rev. 10/08