GENDER PATHWAYS CLINIC

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Welcome to the Gender Pathways Clinic! Thank you for taking the time to fill out this form to help us provide the best possible care for you.

What name would you like us to use?:_____

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other:_____

What is your current gender identity? _____

What was your sex recorded at birth? _____

Legal Name if differs from preferred/Chosen name:_____

If your current name/gender marker is different than your legal name, would you like assistance in legally changing your name/gender marker? ☐ Yes ☐ No

HORMONE HISTORY AND GOALS

Are you currently taking gender-affirming hormones? ☐ Yes ☐ No

If **YES,** when did you start? _____

What is your current dose and frequency: _____

Have you experienced any negative effects from hormones? ☐ No ☐ Yes _____

If you are **NOT** currently taking hormones, are you interested in starting hormones? ☐ Yes ☐ No

What questions or concerns do you have about starting hormones?

_____

SURGICAL HISTORY AND GOALS

Have you had any gender affirming surgeries/treatments in the past?

☐ No ☐ Yes (which ones?) _____

Do you wish to have future surgeries/treatments?

☐ No ☐ Yes (which ones?)_____

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HEALTH HISTORY

Have you ever been diagnosed with any of the following medical conditions?

☐ Heart disease ☐ Diabetes

☐ Liver disease ☐ Tobacco/Nicotine use

☐ High cholesterol ☐ Overweight/Obesity

☐ High blood pressure ☐ Cancer/History of Cancer

☐ Migraine headaches ☐ Seizure disorder/Epilepsy

☐ Eating disorder ☐ Blood clots (in the lung, leg or elsewhere)

Have you been diagnosed with any of the following conditions?

☐ Klinefelter syndrome ☐ Congenital adrenal hyperplasia ☐ Intersex condition

Do you have or had a history of the following mental health problems:

☐ Depression ☐ Suicide attempt/Self harm

☐ Anxiety ☐ Bipolar disorder/Schizophrenia

☐ PTSD ☐ Hospitalizations for any mental health issues/suicide attempt

Are you currently seeing a therapist?

If YES, where? _____ If NO, would you like to? ☐ Yes ☐ No

Are you looking for an affirming primary care doctor?

☐ Yes, I'd like a list of local providers ☐ No, I already have one

Do you live with anyone? ☐ No ☐ Yes, with:_____

Is your current living situation safe? ☐ Yes ☐ No

Are your currently in school and/or working? ☐ No ☐ Yes, at: _____

Do you feel safe in your current school/work place? ☐ Yes ☐ No

Have you ever experienced any form of physical, verbal/sexual/Physical abuse in the past? ☐ Yes ☐ No

If YES, are you currently safe from this abuse? ☐ Yes ☐ No

Is there anything you'd like us to do or avoid doing so as to provide better trauma informed care? ☐ Yes ☐ No

If YES, please explain: _____

Are you concerned about finances, housing, or access to food? ☐ Yes ☐ No

Do you currently use tobacco/nicotine products? ☐ Yes ☐ No

If YES, how much do you smoke per day? _____

Do you currently drink alcohol? ☐ Yes ☐ No

If YES, how many drinks do you have per week? _____

Do you currently use cannabis? ☐ Yes ☐ No

If **YES,** how do you use it and how often? _____

Do you currently use any other substances/drugs? ☐ Yes ☐ No

If **YES,** which ones and how regularly do you use them? _____

Have you used any other substances/drugs in the past? ☐ Yes ☐ No

If **YES,** which ones and how regularly did you use them? _____

Have you ever injected anything that was not prescribed by a doctor? ☐ Yes ☐ No

FAMILY HISTORY

Does anyone in your **immediate** family (parents, siblings) have any these conditions?

☐ Heart Disease or Stroke

☐ Cancers

☐ Blood Clot Problems (DVT, PE)

☐ High Blood Pressure

☐ High Cholesterol

☐ Diabetes

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

Are you sexually active with one partner or more than one? ☐ Yes ☐ No

Are you currently sexually active with someone with a uterus? ☐ Yes ☐ No

Are you currently sexually active with someone who produces sperm? ☐ Yes ☐ No

What parts of your body are involved during sex: ☐ Mouth ☐ Genitals ☐ Anus

Do you use barrier protection (ie. condoms) against sexually transmitted infections (STIs)?

☐ All the time ☐ Sometimes ☐ No

Would you like STI testing today? ☐ Yes ☐ No

FOR SEX RECORDED FEMALE AT BIRTH

Do you bind your chest? ☐ Yes ☐ No

If **YES,** do you experience pain, rash, shortness of breath, or other symptoms? ☐ Yes ☐ No

Would you like more information about binding? ☐ Yes ☐ No

Are you having regular menstrual cycles (every 21-35 days)? ☐ Yes ☐ No

When was your last cycle? _____ Do your cycles cause dysphoria? ☐ Yes ☐ No

Are you currently using birth control? ☐ Yes ☐ No

If **YES,** what are you using? ☐ IUD ☐ Pills ☐ Implant ☐ Shots ☐ Patch ☐ Ring ☐ Condom

Have you had a pap smear in the past? ☐ No ☐ Yes, my last exam was: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you had a mammogram? ☐ No ☐ Yes, my last exam was: _____

Are you currently pregnant or chest feeding? ☐ Yes ☐ No

Do you plan/want to have a genetically similar child in the future? ☐ Yes ☐ No

Would you like to receive information about fertility preservation? ☐ Yes ☐ No

FOR SEX RECORDED MALE AT BIRTH

Is having an erect penis important to your sexual wellbeing? ☐ Yes ☐ No

Do you tuck/compress your genitals? ☐ Yes ☐ No

If **YES,** how/what do you use? _____

Do you experience pain, rash or other symptoms? _____

Would you like more info about tucking? ☐ Yes ☐ No

Do you plan/want to have genetically similar children in the future? ☐ Yes ☐ No

Would you like to receive information about fertility preservation? ☐ Yes ☐ No

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