Patient Name_____

Health History Questionnaire

Your responses to the following questions will provide for a more effective use of your consultation. These questions will help us get to know you better, identify possible health risks, and help us develop a treatment plan together with you. Skip any questions that don't apply due to age or assigned sex.

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).

Patients 13 years of age and older – Please complete all sections on your own, but it's OK the get help from your parents for family information or details about your past medical care.

Parents – Please complete, or assist your child age 12 or under.

General Information

Affirmed/Preferred Name: _____ Today's Date: _____

Legal Name_____ DOB: _____

Best Phone number to contact you, or to leave a detailed medical message (_____) _____-_____

What phone is this? ☐ patient cell ☐ parent cell ☐ land line ☐ other:_____

Reason for Visit: What are your goals for your visit with us?

_____

_____

Who referred you to our clinic, or how did you hear about us?

_____

Who is Your Primary Care Provider?

Name: _____

Telephone: _____

Address: _____

Email: _____

Would you like us to send a copy of your visits here to this provider? ☐ Yes ☐ No

Who is Your Therapist/Mental Health Professional?

Name: _____

Telephone: _____

Address: _____

Email: _____

- Length of time seeing them: _____How Often:_____ Last Visit Date:_____
- Current Diagnoses: _____

Would you like us to send a copy of your visit here to this provider? ☐ Yes ☐ No

Patient Name_____

GENDER HISTORY

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex

Gender Identity: Check any that you use, and would prefer we use

☐ Female ☐ Male
☐ Transgender ☐ Genderqueer
☐ Trans Girl / Trans Woman/ MTF ☐ Trans Boy / Trans Man / FTM
☐ Non Binary ☐ _____

Preferred Gender Pronoun:

☐ He ☐ She
☐ They ☐ Ze
☐ _____

Your story: (let us know more about your journey – use items below, or just let us know in your own words)

Age first noticed gender "incongruence": _____ Example: _____

Age first expressed desire to affirm different gender identity: _____

Example: _____

Age clearly identified as transgender: _____

How would you describe your gender dysphoria?_____

Your feelings about puberty?_____

How would you like people to read your gender presentation?

_____

_____

Have you tried any gender affirming treatments? (HRT, Surgery, Binding, Tucking, etc)

_____

What are your expectations for your transition?

_____

What else should we know? _____

_____

RESOURCES

What resources have you researched ?_____

Please check the box of additional community resources you would like to discuss

☐ Mental Health Referrals ☐ Activities for Trans Youth
☐ Parent Resources ☐ Information on Legal issues, such as name changes
☐ School Related Resources ☐ Fertility Preservation
☐ Sexual Education Resources ☐ Primary Care

Patient Name_____

HEALTH HISTORY

BIRTH Birth Weight: _____

Born close to due date? ☐ Yes ☐ Premature ☐ Late

Pregnancy or Birth Complications? ☐No ☐Yes _____

DEVELOPMENT/LEARNING

Diagnoses or learning concerns, now or in the past? _____

PUBERTY Noticed first changes of puberty at what age?

For Assigned Female: Age noticed chest development _____

For Assigned Male: Age noticed genital growth _____

GYNECOLOGIC HISTORY – Please skip if not applicable.

Age of First Period: _____ Date of Last Period: _____

Frequency of periods: ☐ regular, every month ☐ irregular or spaced more than 5 weeks apart

History of pregnancy: ☐N/A ☐No ☐Yes History of hysterectomy: ☐N/A ☐No ☐Yes

PAST/CURRENT MEDICAL PROBLEMS OR DIAGNOSES

_____

_____

SURGERIES or HOSPITALIZATIONS or EMERGENCY ROOM Please list reason, approximate dates and hospital

_____

_____

CURRENT MEDICATIONS – please include any hormones and/over the counter drugs and supplements as well.

Name of Medication	Dosage	How taken?	Frequency of Use	Date Started / Duration

ALLERGIES – please list any allergies you may have to medications and food.

Medication/Food/Environment/Etc.	Reaction (Symptoms when exposed)
1.	
2.	

Immunizations Up to date? ☐No ☐Yes Flu Vaccine ☐No ☐Yes, Date: _____

Patient Name_____

REVIEW OF SYSTEMS: PAST OR CURRENT CONDITIONS

Please put a **√** if you have experienced any of the following

Ever		Past 3 Months
	Fatigue	
	Fevers	
	Appetite Changes	
	Unexpected Weight Changes □Gain □ Loss	
	□ Blurry Vision or □ Other eye problems	
	□ Ear, □ Nose, or □ Mouth Problems	
	□ Neck Swelling or □ Stiffness	
	□ Cough, □ Wheezing, or □ Breathing Problems	
	□ Palpitations or □ Chest Pain	
	High Cholesterol	
	High Blood Pressure	
	□ Diarrhea or □ Constipation	
	Headache	
	□ Tingling, □ Numbness, or □ Weakness	
	□ Stroke or □ Seizure	
	□ Joint Swelling or □ Muscle Pain	
	Excessive □ Urination or □ Thirst	
	Diabetes	
	Thyroid Problems	
	Feeling unusually □ Cold or □ Warm	
	Vitamin D deficiency	
	□ Anemia or □ Elevated Hemoglobin	
	□ Excessive bruising or □ Blood Clots	
	Sleep problems	
	Depression	
	Anxiety	
	Suicidal thoughts	
	Suicide Attempt	
	Other Psychiatric Problems	
	Other(specify)_____	
	Other(specify)_____	

Please provide details for any checked items:_____

_____

_____

Patient Name_____

FAMILY HISTORY (Only report information for biological relatives)

MOTHER: Height_____ Weight_____

FATHER: Height_____ Weight_____

Please put a **√** next to any conditions that occur in your family and describe who had issue (only consider blood relatives: parents, siblings, grandparents, aunts/uncles)

☐ Thyroid Problems
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Problems
☐ Cancer
☐ Liver problems
☐ Stroke
☐ Heart Attacks
☐ Seizures/Epilepsy
☐ Obesity
☐ Psychiatric Problems
☐ Migraines
☐ Blood problems, such as easy bleeding or blood clots
☐ Arthritis
☐ Infertility
☐ Other: _____

SOCIAL HISTORY

HOME -- Who lives at home with you most of the time? Mark all that apply.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Other significant family members: _____

Do you feel safe at home? _____

SCHOOL: What school do you attend? _____

Current grade or year in school _____ Do you feel safe at school? _____

Have you spoken to the school about your gender identity? _____

What support is available at your school for gender non-conforming students?

_____

During the Past 12 months, how were your grades in school?

☐ About the same as last year ☐ Better than last year ☐ Worse than last year

ACTIVITIES: What are some of your favorite activities (in or out of school)?_____

_____

WORK: (If Applicable)_____

RELIGION: (If Important) _____

Patient Name_____

LIFESTYLE AND HEALTH HABITS

What do you do for exercise? _____ How often/week?_____

Do you use nutritional or vitamin supplements? ☐ No…☐ Yes – which?_____

Do you follow a special diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Low calorie ☐ Other_____

Is your weight ☐ about right ☐ too much ☐ too little

Have you ever ☐ Restricted food intake ☐ Binged ☐ Purged?

Do you drink alcohol? ☐ No ☐ Yes - drink per week? _____

Do you smoke cigarettes or vape? ☐ No ☐ Yes – what/amount per week? _____

Do you use other tobacco products? ☐ No ☐ Yes – what/amount per week? _____

Do you use marijuana products? ☐ No ☐ Yes - amount per week? _____

Do you use other drugs not prescribed to you? ☐ No ☐ Yes

Do you consume caffeinated beverages? (coffee, tea, Monster, Red Bull, Rockstar) ☐ No ☐ Yes:

Beverage_____ - cups per day? _____

SEXUAL IDENTITY

I identify as:

☐ Straight/ heterosexual
☐ Gay
☐ Lesbian
☐ Asexual
☐ Queer
☐ Bisexual
☐ Pansexual
☐ Another_____

SEXUAL HISTORY

Number of sexual partners in last 6 months? _____

Are your partners assigned: ☐ Male ☐ Female ☐ Other: _____

Date of last HIV test: _____ Date of last STD test(s): _____

What safer sex methods do you use, if any? _____

How often? ☐ Always ☐ Often ☐ Sometimes ☐ Never

Are you currently using any method of birth control? ☐ No ☐ Yes; _____

Would you like routine STI testing added to your lab orders? ☐ No ☐ Yes

Are you interested in discussing PrEP? ☐ No ☐ Yes ☐ I don't know what that is

Signature: _____

Printed Name: _____

Thank you!