Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Annual Medical History Update Form

This form helps us learn about your medical history since we last saw you. Not every question is relevant to everyone. If you feel uncomfortable answering a question, leave it blank. We use a harm reduction model of care; therefore, we will never penalize you or deny you care based on what you tell us on this form.

Do you need help with this form? ☐ Yes ☐ No
If you answered yes, please stop filling out the form and speak with a Front Desk staff member.

Person filling out this form (if not the client): _____
Name Relationship to Patient

Medical History

Since we last saw you, do you have any new medical conditions? ☐ None (Skip this section)

_____
_____
_____

Mental Health History

Since we last saw you, do you have any new mental health conditions? ☐ None (Skip this section)

_____
_____
_____

Allergies

Since we last saw you, do you have any new allergies? If yes, what is your reaction? ☐ None (Skip this section)

_____
_____
_____

If your allergic reaction is anaphylaxis, do you have an epi-pen? ☐ Yes ☐ No

Medications

What medicines (prescription and over-the-counter), vitamins, supplements and herbs do you take (regularly and as needed)? ☐ None (Skip this section)

Name	*Dose*	*How often?*	*What is it for?*

Do you often have trouble remembering to take medicines? ☐ Yes ☐ No

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Surgical History

Since we last saw you, what surgeries have you had and when? ☐ None (Skip this section)

_____

_____

_____

Since we last saw you, have you injected or pumped silicone, oils, or other substances for the purpose of body shaping? ☐ Yes ☐ No

Hospitalizations

Since we last saw you, other than for surgery or childbirth, have you been hospitalized overnight for a medical or mental health issue? ☐ Yes ☐ No

If yes, what for and when?_____

Tuberculosis Screening

When was the last time you had a test for tuberculosis (TB)? _____
What was the result?_____
Have you ever had a positive test for TB? ☐ Yes ☐ Unsure ☐ No
If yes, did you complete ≥ 6 months of preventative treatment? ☐ No ☐ Unsure ☐ Yes
Are you experiencing any of the following symptoms?
☐ cough > 3 weeks ☐ unexplained weight loss
☐ coughing up blood ☐ drenching night sweats
Have you had known contact with someone known to have TB disease of the lung? ☐ Yes ☐ No
Were you born in Asia, Africa, Latin America or Eastern Europe? ☐ Yes ☐ No
Have you spent more than 2 weeks in Asia, Africa, Latin America, or Eastern Europe ☐ Yes ☐ No
Have you been in prison/jail in the past 5 years? ☐ Yes ☐ No
Do you work with people who use drugs, are migrant workers, or are experiencing ☐ Yes ☐ No
Are you a health care worker? ☐ Yes ☐ No

Sexual Health & Cancer Screenings

When was your last:			**Date**	**Result**	
Cervical Pap Smear	☐ never	☐ unsure	_____		☐ Not applicable
Anal Pap Smear	☐ never	☐ unsure	_____		☐ Not applicable
HIV Test	☐ never	☐ unsure	_____		☐ Not applicable
Sexually Transmitted Infection Test	☐ never	☐ unsure	_____		☐ Not applicable
Hepatitis C Test	☐ never	☐ unsure	_____		☐ Not applicable
Mammogram	☐ never	☐ unsure	_____		☐ Not applicable
Colorectal Cancer Screening	☐ never	☐ unsure	_____		☐ Not applicable
Bone Density Scan	☐ never	☐ unsure	_____		☐ Not applicable
Cholesterol Lab Test	☐ never	☐ unsure			☐ Not applicable

Since we last saw you, have you tested positive for a new sexually transmitted infection? ☐ No (Skip this section)

If yes, please check all that apply:

☐ HIV/AIDS ☐ Syphilis ☐ Trichomonas
☐ Gonorrhea ☐ Oral Herpes ☐ Bacterial Vaginosis
☐ Chlamydia ☐ Genital Herpes ☐ Yeast Infection
☐ Pelvic Inflammatory Disease ☐ Genital Warts ☐ Molluscum
☐ Not Listed: _____

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

What is your sexuality? (Check all that apply)

- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Pansexual
- ☐ Heterosexual (Straight)
- ☐ Not Listed: _____
- ☐ Dyke
- ☐ Faggot
- ☐ Same Gender Loving
- ☐ Asexual (Ace)
- ☐ Aromantic (Aro)
- ☐ Demisexual
- ☐ BDSM/Kink
- ☐ Skoliosexual
- ☐ T4T (trans for trans)
- ☐ Questioning
- ☐ Don't use labels

When was the last time you had sex or came in contact with another person's bodily fluids?
(ejaculate, discharge, blood, or mucous membranes of the mouth, anus, genitals)
_____ ☐ Not applicable

What is your relationship status?

☐ Polyamorous ☐ Non-monogamous ☐ Monogamous ☐ Single, Dating ☐Single, Not Dating

How many regular sexual partner(s) do you currently have? _____ ☐ None

In the past year, how many different sexual partner(s) have you had? _____ ☐ None

What is the gender of your sexual partner(s)? (Check all that apply)

- ☐ Cis-gender Women
- ☐ Cis-gender Men
- ☐ Trans Feminine
- ☐ Trans Masculine
- ☐ Non-Binary
- ☐ Not Listed: _____

How do you practice "safer sex"?_____

As far as you're aware, do any of your sexual partners have a chronic sexually transmitted infection? (HIV, Genital Warts or HPV, Herpes)	☐ Yes	☐ No
Do you think you or your sexual partner(s) may have a contracted a new sexually transmitted infection recently?	☐ Yes	☐ No
Are you having any difficulties with your sex life?	☐ Yes	☐ No

Have you ever had a menstrual period?	☐ Unsure	☐Yes	☐ No (Skip this section)
Do you currently have periods?	☐ Unsure	☐Yes	☐ No
If no, are you on a medication that stops or affects your period (such as hormones) or have you had a hysterectomy?	☐ Unsure	☐No	☐ Yes (Skip this section)

What was the date that your last normal period began? _____

What are your periods like?

I get one every _____days. It lasts for _____days. On my heaviest day, I use _____pads/tampons/cups

If you get cramps, how severe are they on a scale of 1 (low) to 10 (high)?_____

Are you capable or have you ever been capable of becoming pregnant?		☐ Yes	☐ No (Skip this section)
Since we last saw you, have you had a positive pregnancy test?		☐ Yes	☐ No
Are you planning on becoming pregnant in the future?	☐ Unsure	☐ Yes	☐ No
Do you or your partner(s) use any kind of birth control?	☐ Not needed	☐ Yes	☐ No
If yes, what kind? _____ Are you satisfied with this method?		☐ No	☐ Yes
Could you be pregnant today?		☐ Yes	☐ No

How many times have you:

Been Pregnant? ____ Had an abortion? ____ Had a miscarriage? ____

Had a premature birth? ____ Had a full-term birth? ____ How many live children do you have? ____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Since we last saw you, have you started going through menopause? ☐ Unsure ☐Yes ☐ No (Skip this section)

Have you had any bleeding since starting menopause? ☐ Yes ☐ No
Are you currently having any symptoms of menopause? ☐ Yes ☐ No
If yes, which ones? ☐ Hot flashes ☐ Mood changes
☐ Insomnia ☐ Genital Dryness/Pain with penetration
☐ Not Listed: _____

Mental Health & Substance Use Screening

We ask all clients about safety, depression and substance use, because this can greatly affect your overall health.

Have you ever been non-consensually hit, slapped, kicked, or physically hurt? ☐ Yes ☐ No
If yes, when did this happen? _____
Have you ever been forced or pressured to have sex? ☐ Yes ☐ No
If yes, when did this happen? _____
Do you want to discuss this with your provider today? ☐ Yes ☐ No
Over the past two weeks, how often have you been bothered by:
Having little interest or pleasure in doing things you usually enjoy?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all
Feeling down, depressed, or hopeless?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all
Do you often have trouble sleeping?
☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Do you currently use or have you ever used tobacco products? ☐ Yes ☐ No (Skip this section)

If yes, in terms of tobacco use, are you a:

☐ Current cigarette smoker
When did you first start smoking? _____
How many cigarettes do you smoke per day? _____
Are you interested in quitting? ☐ No ☐ Thinking about quitting ☐ Ready to quit

☐ Former cigarette smoker
When did you quit smoking? _____
On average how many cigarettes did you smoke per day? _____
How many years did you smoke for? _____

☐ Other tobacco user (Circle: cigars, hookah, chew, vape). How often and for how many years?_____

How many times in the past year have you had 4 or more alcoholic drinks in 1 day? ☐ None _____(Skip this section)

Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

How many times in the past year have you used a recreational or prescription drug for non-medical reasons? ☐ None _____ (Skip this section)

What have you used and when did you last use?

☐ Marijuana	_____	☐ Methamphetamines (Crystal Meth)	_____
☐ Rx Opioids (Fentanyl, Codeine, Oxycontin, Vicodin, Percocet, Dilaudid, Morphine, etc)	_____	☐ Rx Stimulants (Ritalin, Adderall, Dexedrine, Concerta, etc)	_____
☐ Heroin	_____	☐ Ketamine (Special K)	_____
☐ Cocaine/Crack	_____	☐ Barbiturates (Phenobarbitol)	_____
☐ Cathinones (Bath Salts)	_____	☐ Sleeping Aids (Ambien, Lunesta, etc)	_____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

☐ MDMA (Ecstasy)	_____	☐ Rohypnol (GHB)	_____
☐ Phencyclidine (PCP)	_____	☐ LSD (Acid)	_____
☐ Anabolic Steroids or Human Growth Hormone	_____	☐ Mushrooms	_____
☐ Benzodiazepines (Xanax, Klonopin, Ativan, etc)	_____	☐ DMT (Ayahuasca)	_____
☐ Nitrous Oxide (Whippits)	_____	☐ Peyote (Mescaline)	_____
☐ Alkyl Nitrites (Poppers)	_____	☐ Not Listed:_____	_____

If you use opioids, do you have access to Narcan (Naloxone)? ☐ Not Applicable ☐ No ☐ Yes
Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

Nutrition & Exercise

How many servings per day do you eat:
Fruit? _____ Vegetables? _____ Foods with calcium? _____
(milk, cheese, yogurt, soy milk, tofu, quinoa, greens, etc)

How easy is it for you to access these foods?
☐ Very difficult ☐ Somewhat hard ☐ Easy

How many times per week do you consume the following:
Fast food? _____ Fried food? _____ Sugary drinks? _____
(Soda, juice, sports, or energy drinks, etc)

Do you feel like you eat the right amount of food? ☐ Too little ☐ Too much ☐ The right amount
Are you concerned about your weight? ☐ Yes ☐ No
Do you exercise? ☐ No ☐ Yes
If yes, what do you do? _____
How many times per week? _____How long do you spend working out at a time? _____

Dental History

Have you seen a dentist in the last 6 months? ☐ No ☐ Yes
Do you have difficulty chewing or swallowing? ☐ Yes ☐ No
Do you brush your teeth daily? ☐ No ☐ Yes
Do you floss daily? ☐ No ☐ Yes

Health Directive

Do you have a California Health Care Directive? (a legal document that specifies what actions should be taken if you are no longer able to make decisions for yourself) ☐ No ☐ Yes
Do you have someone to call if you need help in an emergency? ☐ No ☐ Yes
If you are over 50, do you have someone to help you make decisions about your health? ☐ No ☐ Yes

Employment, Housing, & Transportation

Are you working or in school? (Check all that apply)

- ☐ Yes, my current job is: _____
- ☐ No, I'm unemployed
- ☐ No, I'm retired
- ☐ No, I'm on disability for: _____
- ☐ Yes, I'm in school for: _____

What is your current living situation?

- ☐ House or Apartment (Stable/Permanent)
- ☐ In a Residential Treatment Program
- ☐ In a Shelter
- ☐ With friends/family (Temporary)
- ☐ In a Vehicle
- ☐ On the Street
- ☐ In a Single Room Occupancy (SRO) Hotel since _____

Who do you live with? _____
Do you feel safe in your living situation? ☐ No ☐ Yes
If you are over 50 and/or disabled, do you sometimes fall? Is it hard to get up? ☐ Yes ☐ No
Are there guns in your home? ☐ Yes ☐ No
Do you, your friends, or your family smoke in your home or place you live? ☐ Yes ☐ No
Are there working smoke detectors in your home? ☐ No ☐ Yes

Name (to be called) _____Name Listed with Insurance (if different):_____
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Are you a primary caretaker for children, your parents or other adults? ☐ Yes ☐ No
Do you have any pets or a support animal? ☐ Yes ☐ No
When in a car, do you wear a seatbelt? ☐ No ☐ Yes
When riding a motorcycle, do you wear a helmet? ☐ No ☐ Yes
When riding a bicycle, do you wear a helmet? ☐ No ☐ Yes
Have you had any transportation-related accidents recently? ☐ Yes ☐ No
Are family members/friends worried about you driving? ☐ Yes ☐ No

Gender History

Are you transgender, non-binary, gender non-conforming or have a history of gender transition? ☐ Yes ☐ No (Skip this section)

*****If nothing has changed since the last time you filled this form out, feel free to skip this section*****

What is your gender identity? (Check all that apply):

☐ Woman	☐ Trans	☐ Tomboy	☐ Non-Binary
☐ Man	☐ Transgender	☐ Two-Spirit	☐ Genderfuck
☐ MTF	☐ Transsexual	☐ Hijra	☐ Bi-Gender
☐ FTM	☐ Femme	☐ Kathoey	☐ Multi-Gender
☐ Trans Feminine	☐ Butch	☐ Muxe	☐ Pangender
☐ Trans Masculine	☐ Stud	☐ Khanith	☐ Gender Creative
☐ Transguy	☐ Aggressive (AG)	☐ Gender Non-Conforming	☐ Gender Expansive
☐ Feminine-of-Center	☐ Boi		☐ Third Gender
☐ Masculine-of-Center	☐ Androgynous	☐ Genderqueer	☐ Agender/Neutrois
☐ T-Girl	☐ Demigirl	☐ Gender Variant	☐ Questioning
☐ T-Boy	☐ Demiboy	☐ Gender Fluid	☐ Don't use labels
☐ Not Listed:_____			

At what age did you first feel your gender identity differed from the gender that's assumed to align with the sex you were assigned at birth? _____

Have you ever felt anxious, depressed, or suicidal because your physical appearance does not align with your gender identity? ☐ Yes ☐ No

Are the following people aware of and supportive of your transition/gender identity and expression?

Significant other(s)	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes
Family of origin	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes
Support group	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes
Friends	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes
Therapist	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes
School	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes
Employer	☐ Not Applicable	☐ No	☐ Sometimes	☐ Yes

What are your fears (if any) about coming out or being trans or gender non-conforming?

_____

Have you changed your name and/or gender marker on all of your identity documents? ☐ No ☐ Yes (Skip to next question)

If no, do you want to update any of your identity documents? ☐ Yes ☐ No (Skip to next question)

If yes, which documents would you like to update?

- ☐ Social Security Card
- ☐ Driver's License or State-Issued ID
- ☐ Passport
- ☐ Green Card
- ☐ Birth Certificate (if checked, please tell us which state you were born in)_____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

What would you like to change?

- ☐ Name only
- ☐ Gender Marker only (will need doctor's letter to change federal identity documents)
- ☐ Name and Gender Marker (will need doctor's letter to change federal identity documents)

Do you use any prosthetics or compression techniques to express your gender?
(Bind, pack, breast forms, padding, tuck, etc.) ☐ Yes ☐ No
(Skip to next question)

If yes,

How many hours per day? _____

What do you use? (binder, duct tape, KT tape, ace bandage, gaffe, packer, breast forms, tissue paper, socks, etc.)

_____

Do you have any complications? (chronic pain, UTIs, fungal infections, rashes, acne, broken bones, etc.)

_____

Have you ever discussed medical transition (hormone therapy and/or surgery with a health care provider before? ☐ Yes ☐ No or N/A
(Skip to next question)

If yes, when were you first diagnosed with gender dysphoria?_____

What clinic or provider diagnosed and treated you?_____

If you are currently on hormone therapy,

When did you first start hormone therapy? _____

What is the current formulation and dose of your medication?

Medication (example: testosterone cypionate 200mg/mL):_____

Route (example: Injection, Patch, Gel, Pill):_____

Dose (example: 0.3mL):_____

How often (example: every week):_____

Do you have any concerns or issues with hormone therapy you would like to discuss?

_____

If you are not currently taking hormones,

Were you on hormones therapy in the past? ☐ Yes ☐ No

Are you interested in starting or re-starting hormone therapy? ☐ Yes ☐ No

If yes, what are you hoping hormones will do for you?

_____

If yes, what (if any) are your concerns about taking hormones?

_____

Are you interested in pursuing any gender affirming surgeries? ☐ Yes ☐ No
(Skip this question)

If yes, which surger(ies)? (Check all that apply)

- ☐ Mastectomy (top surgery)
- ☐ Hysterectomy (removal of uterus)
- ☐ Oophorectomy (removal of ovaries)
- ☐ Metoidioplasty
- ☐ Vaginectomy
- ☐ Urethral Lengthening
- ☐ Scrotoplasty
- ☐ Phalloplasty
- ☐ Not Listed: _____
- ☐ Breast Augmentation (implants)
- ☐ Orchiectomy (removal of testes)
- ☐ Vulvoplasty
- ☐ Vaginoplasty
- ☐ Tracheal Shave (adam's apple reduction)
- ☐ Facial Hair Reduction (laser or electrolysis)
- ☐ Facial Gender Confirmation Surgery
- ☐ Body Contouring

Thank you for taking the time to complete this form!

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____