Date: _____ new trans patients

Name _____ Birthdate _____ Chart No. _____

Transgender History/Intake: This form should be done in addition to the regular intake form. It tells us more about you as a transgender person and how we can help you. Lyon-Martin uses a *Harm Reduction* method to help transpeople. We want to keep you safe and healthy. We know that not everyone needs to or can follow the WPATH (formerly HBIGDA) Standards of Care. We will ***NEVER*** penalize you or deny you care based on what you tell us on this form. If you feel uncomfortable answering a question, leave it blank.

How do you identify (check all that apply):

☐ man ☐ transgender ☐ FTM ☐ genderqueer
☐ woman ☐ transsexual ☐ MTF ☐ intersex
☐ other: _____

At what age did you first feel your gender identity did not match your physical body? ____

Have you ever felt depressed or suicidal because your gender identity does not match your body? ☐ yes ☐ no

Who is in your support system? Who do you talk to about your problems (e.g. feeling sad or angry)?

☐ Significant other ☐ Family of origin ☐ Support group
☐ Friends ☐ Therapist ☐ Other: _____

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

Employer/School ☐ no ☐ yes
Family of origin ☐ no ☐ yes
Significant other ☐ no ☐ yes
Friends ☐ no ☐ yes

Are you out at work/school?

☐ No one knows ☐ Some people know ☐ Everyone knows

If not, would you be safe if you chose to come out? ☐ no ☐ yes

What are your fears (if any) about coming out or being transgender?

_____

Have you legally changed your name? ☐ no ☐ yes
If no, do you want to ☐ yes ☐ no
do you want to discuss this with your provider today? ☐ yes ☐ no

Have you changed your gender on your IDs? ☐ no ☐ yes
If no, do you want to ☐ yes ☐ no
do you want to discuss this with your provider today? ☐ yes ☐ no

Have you ever seen a health care provider about being transgender? ☐ yes ☐ no

If yes, when were you first diagnosed or treated? _____
who diagnosed/treated you? _____
where are they located? _____

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I reviewed this page: _____

LYON-MARTIN HEALTH SERVICES
1748 Market St., Suite 201, San Francisco, CA 94102-5806
Telephone: (415) 565-7667

What hormone treatments have you been on, when, and for how long? These can be ones you were prescribed, that you shared with others or that you bought without a prescription. Include any treatment you currently take. ☐ **None**

Name	Dose	When did you start it?	How long did you take it for?

Have you ever had any problems, complications, or other difficulty with hormone treatment? ☐ yes ☐ no

If you are not currently taking hormone treatment, would you like to? ☐ yes ☐ no

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

_____

_____

what are your worries about taking hormone treatment?

_____

_____

what do you know about the risks/side effects?

_____

_____

Do you know how to self-inject safely? ☐ no ☐ not sure ☐ yes

Do you want to discuss this with a provider today? ☐ yes ☐ no

Have you had any 'sex-reassignment-surgery'? ☐ yes ☐ no

Do you want to have surgery now or in the future? ☐ yes ☐ not sure ☐ no

If yes, what kind of surgery would you want? (check all that apply)

☐ Chest reconstruction (top surgery) ☐ Breast augmentation (implants)
☐ Hysterectomy (removal of uterus) ☐ Orchiectomy (removal of testes)
☐ Oophorectomy (removal of ovaries) ☐ Vaginoplasty
☐ Metoidioplasty ☐ Trachael shave
☐ Phalloplasty ☐ Facial feminization surgery
☐ Other: _____

If you are on or considering taking testosterone, have you ever had any of the following signs or symptoms (before taking Testosterone)?

☐ Tallest child in the 1st and 2nd grade ☐ Facial hair
☐ Growth of pubic hair before age 8 ☐ Irregular periods
☐ Onset of menses before age 9 ☐ Deep voice
☐ Increased weight or musculature ☐ Enlarged clitoris
☐ More than usual acne as teenager ☐ Acne as an adult

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I reviewed this page: _____