**Neck:**

◯ Goiter ◯ Lumps ◯ Swollen Glands ◯ Pain

**Respiratory:**

◯ Cough ◯ Wheezing ◯ Shortness of breath ◯ Coughing up blood

**Cardiac:**

◯ Heart Murmur ◯ Chest Pain ◯ Palpitations ◯ Swelling of feet ◯ Shortness of breath

**Gastrointestinal:**

◯ Trouble swallowing ◯ Heartburn or gas ◯ Nausea ◯ Vomiting ◯ Rectal Bleeding ◯ Constipation

◯ Diarrhea ◯ Abdominal Pain ◯ Hemorrhoids

**Urology:**

◯ Frequent urination ◯ Painful urination ◯ Blood in urine ◯ Stones ◯ Difficulty urinating/holding

**Musculoskeletal:**

◯ Joint stiffness ◯ Arthritis ◯ Gout ◯ Backache ◯ Muscle pain or cramps

**Peripheral Vascular:**

◯ Leg Cramps while walking ◯ Varicose Veins ◯ Thrombophlebitis

**Neurological:**

◯ Fainting ◯ Blackouts ◯ Seizures ◯ Weakness ◯ Numbness ◯ Tremors ◯ Tingling of hand/feet

◯ Memory changes

**Psychiatric:**

◯ Anxiety ◯ Depression ◯ Phobias ◯ Eating Disorder ◯ Confusion ◯ Speech/Memory disorder

**Endocrine:**

◯ Hear or cold intolerance ◯ Excessive Sweating ◯ Excessive Urinating ◯ Excessive Hunger ◯ Anemia

◯ Easy Bruising or Bleeding

**Other:**

**Have you ever been hit, slapped and/or kicked or otherwise physically hurt by someone?**

◯ YES, in the past year ◯ YES, prior to this past year ◯ NO

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**Has anyone ever forced you into having any type of sexual activity?** ◯ Yes ◯ No

**Do you experience chronic pain?** ◯ Yes ◯ No

**If YES**, how is your pain managed? (i.e. Physical Therapy, medication, etc.) _____

**OPERATIONS AND HOSPITALIZATIONS:**

Please list any surgeries and/or hospitalization reasons and date: _____

_____

_____

**ALLERGIES TO MEDICATIONS:** _____

_____

**CURRENT MEDICATION:** (Please include any over-the-counter drugs as well as vitamins, aspirin, etc.)

| Medication Name | Dose | Frequency of Use |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If you need additional room, please list other medications on the back of this page.

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## FAMILY MEDICAL HISTORY

Please check all that apply:

◯ Stroke ◯ Heart Disease ◯ High Blood Pressure ◯ Thyroid Disease ◯ Kidney Disease

◯ Diabetes ◯ Arthritis ◯ Osteoporosis ◯ Migraine Headaches ◯ Alcoholism ◯ Asthma

◯ Depression ◯ Anxiety ◯ Cancer (Type): _____

## VACCINATIONS/PREVENTION

**Date of last Tetanus Vaccination:** ___/___/___

**Have you received any of the following vaccines:**

Hepatitis A: ◯ Yes ◯ No ◯ Not sure

Hepatitis B: ◯ Yes ◯ No ◯ Not sure

Pneumo Vax: ◯ Yes ◯ No ◯ Not sure

**Have you had a blood test for Rubella (German Measles)**

◯ Yes ◯ No ◯ Not sure

**Date of last Colonoscopy:** ___/___/___

Check here if Not Applicable: _____

**How often do you wear seatbelts?** _____

**Are there any firearms kept in your home?** ◯ Yes ◯ NO

Does someone have a **Power of Attorney or Healthcare Proxy** giving them the power to make decisions about your care in life-threatening situations? ◯ Yes ◯ No **Name of Person/Relationship:** _____

Do you have an **Advanced Directive** such as **DNR** (Do not resuscitate)? ◯ Yes ◯ No

## GENDER IDENTITY

Please list any questions, concerns or comments you have, if any, about your gender, gender identity (sense of your Femaleness or Maleness) or sexual concerns. _____

_____

_____

## SEXUAL ORIENTATION & SEXUAL HISTORY

**How do you identify yourself in terms of sexual orientation?** _____

**Are you attracted to the following:** (check all that apply)

◯ Men ◯ Women ◯ Transgender Men ◯ Transgender Women ◯ Asexual ◯ Questioning

**Have you had sex with the following:** (check all that apply) ◯ Men ◯ Women ◯ Transgender Men ◯ Transgender Women

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**When you have sex, do you have the following:** (check all that apply)

◯ Oral Sex ◯ Vaginal Sex ◯ Anal Sex

**How often do you use condoms when having the following:**

◯ Always ◯ Sometimes ◯ Never

**When was the last time you had sex without using a condom?** _____

**Do you have a Primary Sexual Partner?** ◯ Yes ◯ No **Do you have any Casual Sexual Partners?** ◯ Yes ◯ NO

**When was the last time you were tested for HIV?** _____ **What were the results:** ◯ Negative ◯ Positive

**Please check any of the following that may apply:**

◯ Syphilis ◯ Gonorrhea ◯ Pelvic Inflammatory Disease ◯ Herpes ◯ Trichomonas

◯ Genital Warts ◯ Yeast Infections ◯ Bacterial Vaginosis ◯ Chlamydia ◯ Crabs

For each of the above that you checked, please indicate the **date of infection, treatment completed, were your partner (s) informed and/or if you need help telling your partner(s)**.

| **Infection** | **Date** | **Treatment Completed** | **Inform Your Partner** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Do you know or believe that any of your partners have had HIV or another sexually transmitted infection?**

◯ Yes ◯ No ◯ Not Sure

**Have your current partners been tested for HIV or other sexually transmitted infections?** ◯ Yes ◯ No ◯ Not sure

**What were their results?** ◯ Negative ◯ Positive ◯ Not Sure

**Are you satisfied with your sexual life?** ◯ Yes ◯ No ◯ Not sure

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## GYNECOLOGIC HISTORY

If **not applicable** due to sex and/or gender, **Please check here ____ and skip** to Hormones Section.

**Age of First Menstrual Period:** _____ **Date of Last PAP:** _____ **Results:** ◯ Normal ◯ Abnormal

**Have you ever had the following:** (check all that apply)

Abnormal PAP: ◯ Yes ◯ No Ovarian Cysts: ◯ Yes ◯ No Fibroids: ◯ Yes ◯ No

DES Exposure: ◯ Yes ◯ No Have you had a Hysterectomy: ◯ Yes ◯ No **If YES, Why?** _____

**Were your ovaries removed?** ◯ Yes, One ◯ Yes, both ◯ No

If **Menopausal** or **Postmenopausal,** Please **check here _____ and skip** to the next section**.**

**Date of Last Period:** _____ **Frequency of Periods:** _____ **Bleeding:** ◯ Light ◯ Moderate ◯ Heavy

**Other bleeding:** ◯ Yes ◯ No **Between Periods:** ◯ Yes ◯ No ◯ After penetrative sexual activity

**Do you experience any of the following symptoms with your period?** (check all that apply)

◯ Headaches ◯ Weight Gain ◯ Swelling ◯ Cramps ◯ Anxiety ◯ Depression ◯ Other _____

**Are you currently using birth control?** ◯ Yes ◯ No **If YES**, which type: (check all that apply)

◯ IUD ◯ Condoms ◯ Foam ◯ Foam & condoms ◯ Patch ◯ Diaphragm

◯ Ring ◯ Depo ◯ Tubal Ligation ◯ Vasectomy ◯ Pills (how long?)_____

**Are you currently pregnant or planning to become pregnant?** ◯ Yes ◯ No

If you have not begun **Menopause**, Please **check here ____ and skip** to next section

**Age when Menopause began:** _____ **Have you ever taken estrogen replacement?** ◯ Yes ◯ No

**Age when estrogen replacement was started:** _____ **How long was the estrogen replacement used?** _____

**What was the estrogen dose?** _____ **Have you ever taken progesterone?** ◯ Yes ◯ No

**If YES,** what was the name of the progesterone replacement? _____

**How often did you take it?** (days per month) _____ **How long did you use it?** _____ **What was the dose?** _____

**Please check any of the following symptoms of Menopause you are having:**

◯ Hot Flashes ◯ Fatigue ◯ Anxiety ◯ Depression ◯ Insomnia ◯ Irregular Bleeding

◯ Vaginal Burning/Itching ◯ Vaginal Dryness ◯ Pain during Vaginal Penetration ◯ Other: _____

## OBSTETRIC HISTORY

**How many times have you been pregnant?** _____ **How many miscarriages have you had?** _____

**How many pregnancy terminations have you had?** _____ **How many vaginal deliveries have you had?**_____

**How many caesarean sections have you had?** _____

**Have you had any of the following:** (check all that apply)

Ectopic Pregnancies ◯ Yes ◯ No Gestational Diabetes ◯ Yes ◯ No History of Infertility ◯ Yes ◯ No

## HORMONES FOR GENDER/SEX TRANSITIONING

If **Not** applicable, please **check here ____ and skip** to the next section.

**Are you currently taking hormones for gender or sex transitioning purposes?** ◯ Yes ◯ No

**If Yes, how long have you been taking them?** _____ **What hormones are you taking?** _____

**Have you ever used transitioning hormones in the past?** ◯ Yes ◯ No **If YES, to past or current hormone use, what type of complications, if any, have you experienced?** _____

**What type, if any, of sex reassignment surgery have you had?** _____

**What type, if any, of other feminizing or masculinizing procedures have you had?** _____

**What type of complications, if any, have you experienced following such surgeries and/or procedures?**

_____

**What concerns or questions, if any, do you have regarding gender/sex transitioning?**_____

_____

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## LIFESTYLE & HEALTH HABITS

**Do you follow a special diet?** ◯ Yes ◯ No If **YES, please check** all that apply:

◯ Vegetarian ◯ Low Fat ◯ Low Carb ◯ High Fiber ◯ Calorie Restriction ◯ Other

**Have you ever hinged, purged or restricted your food intake?** ◯ No ◯ Yes, describe: _____

_____

**What concerns do you have about your eating practices?** _____

**How often do you exercise at a moderate or vigorous level for 30 minutes or more?** _____

**What type of exercise and/or sports do you engage in?** _____

**On a typical day, how many cups of caffeine containing beverages do you have?** _____ (coffee, tea, soda, energy drinks, etc).

**On a typical day, how many portions of calcium enriched foods do you eat?** _____

**On a daily basis, how much calcium do you consume through tablets or chews?** ____ ◯ 500 mg ◯ 600-1200 mg

## SUBSTANCE USE HISTORY

**How many drinks containing alcohol do you have, on an average, per week?** _____

**Have you ever been concerned about drinking?** ◯ Yes ◯ No ◯ Not Sure

**Has anyone, including a family member, friend, or healthcare worker been concerned about your drinking or suggest you cut down?** ◯ Yes ◯ No ◯ Not Sure

**Are you a former smoker?** ◯ Yes ◯ No ◯ N/A **How long ago did you quit?** _____

**How many cigarettes do you smoke per day?** _____ **How old were you when you first started smoking?** _____

**Have you tried to quit?** ◯ Yes ◯ No ◯ N/A **Are you interested in quitting?** ◯ Yes ◯ No ◯ N/A

**Please check any of the substances listed below that you have used, even if it was only once:**

◯ Marijuana ◯ Cocaine ◯ Crystal Meth ◯ Heroin ◯ Other Opiates (Oxycodone, Vicodin, etc.)

◯ Ecstasy ◯ Mushrooms ◯ LSD ◯ Other Substances

**When was the last time you used it and how often?** _____

**How did you use it** (i.e. Smoke, inject, etc.) _____

**Did you ever share your needle, cooker, cotton, rinse or any other part of your set?** ◯ Yes ◯ No ◯ Not Sure

**What type of problems has drug use cause for you** (i.e. relationships with others, problems at work, depression, anxiety, physical health, etc. )_____

_____

_____

_____

**What concerns, if any, do you have about either your past or current drug use?** _____

_____

_____

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide a more complete and knowledgeable care of you. If you have any questions, please see our clinic staff.