# University of Washington Medical Center
## *University Reproductive Care*

# TRANSGENDER NEW PATIENT HISTORY

Please complete this form and bring it with you to your scheduled appointment.

**CONTACT INFORMATION**:

Legal Name: _____ Middle Initial: ____ Last Name:_____

Preferred Name: _____ Gender Identity: _____

Legal sex: _____ Sex Assigned at Birth:_____

Preferred pronouns (he/him, she/her, they/them etc.) _____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

□ Home Phone: (___) _____ □ Cell Phone: (___)_____ □ Work Phone:(___)_____

Are you married? □ Yes □ No □ Divorced □ Other _____

**Spouse/Partner:** □ Not Applicable

First name: _____ Middle Initial: ____ Last Name:_____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

□ Home Phone: (___) _____ □ Cell Phone: (___)_____ □ Work Phone:(___)_____

**Who referred you?**

□ Physician Name: _____Clinic: _____

Phone: (___)_____Address: _____

□ Former Patient/Friend: _____

□ Website/Advertisement: _____ □ Insurance Carrier:_____

PLACE PATIENT LABEL HERE

**Who is your mental health specialist?**

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

**Who is your primary care provider?**

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

**MEDICAL HISTORY AND INFORMATION**:

**Reason for visit?** □ Hormone transition □ Hormone management □ Fertility preservation
□ Other_____

**What is your primary goal for this visit?**_____
_____

**Do you have any personal, ethical or religious objections** to any of our tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.?
□ **No** □ Yes _____

**Menstrual History**: □ Not applicable
Age when you had your first period: _____
Age when you first noticed breast development: _____ pubic hair: _____underarm hair: _____

**Current menstrual cycle pattern:** □ Not applicable
□ Regular □ Irregular (if irregular check all that apply)
□ <25 days □ >35 days □ No periods □ Bleed between periods □ Bleed after sex
Number of days between the start of one period to the start of the next period: _____
How many periods do you have a year? _____ How many days of bleeding do you have?_____
Dates of the 1st day of your last 2 periods (month/day/year): ____/____/____ , ____/____/____
If you no longer have periods, at what age did you stop having them? _____
Do you have severe menstrual cramps/pain? □ **No** □ Yes: Always __Sometimes __ In the Past___

**Contraceptive History**: (please check all that apply and provide dates of use) □ None
□ Condoms: _____ □ Diaphragm_____ □ IUD_____
□ Implanon/Nexplanon_____ □ Birth control pills_____
□ Patch _____ □ Nuva-ring _____
□ Injectable (Depo-Provera, Lunelle etc.) _____
□ Tubal sterilization (tubes "tied," cut, burned, Essure, etc.) Date: ____/____/____ Type:_____

**Sexual History**:
□ Are you sexually active? □ Yes □ No
□ Sex and/or gender of your sexual partner(s) _____
□ Have you used over-the-counter ovulation kits to assess ovulation? □ No □ Yes □ Not applicable
□ Do you have pain with sex? □ **No** □ Yes
□ Do you use lubricants (K-Y Jelly, etc.) during sex? □ Yes- what type? _____ □ **No**

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
□ **No** □ Yes (Please check all that apply and the date of diagnosis)
□ Chlamydia _____ □ Gonorrhea _____
□ Herpes _____ □ Hepatitis B _____
□ Genital warts (HPV) _____
□ Syphilis _____ □ HIV/AIDS _____

**ZIKA and West Nile exposure**
Have you (or your partner) traveled to a Zika Virus Zone? □ **No** □ Yes
Have you (or your partner) traveled to a West Nile Zone? □ **No** □ Yes
Do you (or your partner) plan to travel to a Zika virus or West Nile zone? □ **No** □ Yes

Have you (or your partner) experienced any of the following in the last 6 months?
Fever: □ **No** □ Yes Rash: □ **No** □ Yes Joint pain or body aches: □ **No** □ Yes
Conjunctivitis: □ **No** □ Yes Headache: □ **No** □ Yes

Have you been treated for or diagnosed with one of the following problems?
□ **No** □ Yes (Please check all that apply and provide the date of diagnosis)
□ Ovarian failure_____ □ Ovarian cysts (specify type)_____ □ Fibroids_____
□ Endometriosis_____ □ Tubal disease_____ □ Uterine polyps _____ □ Adrenal disease
□ Pelvic inflammatory disease (PID)_____ □ PCOS_____ □ Thyroid disease_____

**Pap Smear History**: □ Not applicable
When was your last pap smear (month and year)? ____/____
Have you ever had an abnormal pap smear □ No □ Yes
If yes, when was your last abnormal pap smear?____/____
Have you had any of the following treatments for abnormal pap smear? (please check all that apply)
□ Colposcopy □ Cryosurgery (freezing) □ LEEP procedure □ Conization

**Breast Screening History**: □ Not applicable
Do you perform breast self-exams? □ No □ Yes
Have you ever had a mammogram? □ No □ Yes – date ___/___/_____
Result: □ Normal □ Abnormal – explain _____

**Prostate Screening History:** ☐ Not applicable
Have had prostate screening? ☐ No ☐ Yes – date ___/___/___
Have you ever had a PSA test? ☐ No ☐ Yes – date ___/___/___
Result: ☐ Normal ☐ Abnormal – explain _____

**Pregnancy Summary:** ☐ N/A
☐ Total Number of ALL pregnancies: _____ ☐ Number of living children _____
☐ Miscarriages (less than 20 weeks): _____ ☐ Ectopic/tubal Pregnancies: _____
☐ Elective Terminations (Abortions): _____
☐ Full Term Deliveries:_____ ☐ Premature Deliveries (less than 37 weeks): _____
☐ Any Pregnancies with birth defects? ☐ **No** ☐ Yes _____

| Date Pregnancy Ended or Delivered | Months to Conception | Treatment to Conceive | Delivery Type D&C/Complications | Current Partner? |
|---|---|---|---|---|
| 1. | | | | ☐ Yes ☐ No |
| 2. | | | | ☐ Yes ☐ No |
| 3. | | | | ☐ Yes ☐ No |
| 4. | | | | ☐ Yes ☐ No |

**Medical History**:
Are you allergic to any medications or foods? ☐ **No** ☐ Yes
(list allergies and describe reactions)

| Drug or food | Reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

| Medication | Dose | Why are you taking this medication |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

PLACE PATIENT LABEL HERE

Do you have any medical problem(s)? ☐ **No** ☐ Yes (please list type, dates and treatments)

| Medical problem | Diagnosis date | Treatments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Surgical History**: Have you had any surgeries including gender affirming surgery? ☐ **No** ☐ Yes

| Year | Type of surgery and reason for surgery |
|---|---|
| | |
| | |
| | |

Any anesthesia problems? ☐ **No** ☐ Yes (describe)_____

**Social History**:
Number of caffeinated beverages (coffee, tea, soda) per day? _____
Do you smoke cigarettes? ☐ **No** ☐ Quit/when_____ ☐ Yes
Number of years_____ Number of cigarettes per day _____
Do you drink alcohol? ☐ **No** ☐ Yes
Number of drinks per week: Beer ____ Wine ____ Liquor _____
Do you use recreational drugs (i.e. marijuana)? ☐ **No**
☐ Yes (describe) _____
Do you exercise? ☐ No ☐ **Yes**-- Number of hours per week _____
Type_____

**Review of Physical Symptoms**:

**General**
☐ Fever/chills
☐ Recent weight gain or loss
☐ Anorexia/bulimia
☐ Lack of energy
☐ Other:_____
☐ **None**

**Head, Eyes, Ears, Nose and Throat**
☐ Hearing loss/deafness
☐ Loss of sense of smell
☐ Chronic nasal congestion
☐ Blurred vision
☐ Ringing ears
☐ Other:_____
☐ **None**

**Respiratory**
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Tuberculosis
☐ Pneumonia
☐ CPAP machine
☐ Other_____
☐ **None**

**Endocrine/Hormonal**
- ☐ Thyroid gland problems
- ☐ Diabetes
- ☐ Frequently hot or cold
- ☐ Hot flashes
- ☐ Increased hunger/thirst
- ☐ Adrenal disorder
- ☐ Other_____
- ☐ **None**

**Breasts**
- ☐ Surgery (Type:_____)
- ☐ Discharge (Type:_____)
- ☐ Lumps
- ☐ Pain
- ☐ Cancer
- ☐ Other_____
- ☐ **None**

**Neurological**
- ☐ Dizziness
- ☐ Weakness or loss of balance
- ☐ Seizures/Epilepsy
- ☐ Stress headaches
- ☐ Migraine headaches
- ☐ Memory Loss
- ☐ Other_____
- ☐ **None**

**Mental Health**
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar depression disorder
- ☐ Personality disorder
- ☐ Eating disorder
- ☐ Suicidal
- ☐ Other_____
- ☐ **None**

**Kidney/Urinary**
- ☐ Kidney cysts
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Other_____
- ☐ **None**

**Skin/Extremities**
- ☐ Hair loss
- ☐ Rash
- ☐ Acne
- ☐ Skin cancer
- ☐ Excessive facial or body hair
- ☐ Eczema
- ☐ Other_____
- ☐ **None**

**Cardiovascular**
- ☐ Murmurs
- ☐ Chest pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Mitral valve prolapse (antibiotics are required with dental procedures ☐ No ☐Yes)
- ☐ Other:_____
- ☐ **None**

**Hematologic**
- ☐ Blood clots
- ☐ Sickle cell anemia
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Stroke
- ☐ Blood Transfusion date and reason:_____
- ☐ Other_____
- ☐ **None**

**Musculoskeletal/Immune**
- ☐ Osteoporosis
- ☐ Decreased energy/fatigue
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematosus
- ☐ Myasthenia gravis
- ☐ Other_____
- ☐ **None**

**Gastrointestinal**
- ☐ Ulcers
- ☐ Nausea/Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Blood in stool
- ☐ Irritable bowel disease
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other:_____
- ☐ **None**

| Family History | Living | Age and Cause of Death |
|---|---|---|
| Mother | ☐ Yes – age: ☐ No | |
| Father | ☐ Yes – age: ☐ No | |
| Brothers (number=___) | ☐ Yes – ages: ☐ No | |
| Sisters (number=____) | ☐ Yes – ages: ☐ No | |
| Maternal Grandmother | ☐ Yes – age: ☐ No | |
| Maternal Grandfather | ☐ Yes – age: ☐ No | |
| Paternal Grandmother | ☐ Yes – age: ☐ No | |
| Paternal Grandfather | ☐ Yes – age: ☐ No | |

Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ **No** ☐ Don't know

| **Disorders in Your Family** | | **Relationship to you** | | |
|---|---|---|---|---|
| Breast Cancer | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Ovarian Cancer | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Colon Cancer | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Other Cancer_____ | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Diabetes | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Thyroid Problems | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Heart Disease | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Blood Clots | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Psychiatric Problems | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Tuberculosis | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Endometriosis | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Menopause before age 40 | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Birth Defects | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Cystic Fibrosis | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Tay-Sachs Disease | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Canavan Disease | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Bloom Syndrome | ☐Yes | _____ | ☐ No | ☐ Don't Know |
| Gaucher Disease | ☐Yes | _____ | ☐ No | ☐ Don't Know |
| Niemann-Pick Disease | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Fanconi Anemia | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Familial Dysautonia | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Muscular Dystrophy | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Neurologic (brain/spine) | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Neural Tube Defects | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Bone/Skeletal Defects | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Dwarfism | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Developmental Delays | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Learning Problems | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Polycystic Kidneys | ☐ Yes | _____ | ☐ No | ☐ Don't Know |
| Heart defect from birth | ☐ Yes | _____ | ☐ No | ☐ Don't Know |

**What is Your Race/Ethnicity?**

- ☐ African American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian American
- ☐ Cajun/French Canadian
- ☐ Caucasian/ White
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other: _____

**Would you like to be screened for?**

| | | |
|---|---|---|
| Cystic Fibrosis | ☐ Yes | ☐ No |
| Sickle Cell Anemia | ☐ Yes | ☐ No |
| Tay-Sachs disease | ☐ Yes | ☐ No |
| Thalassemia | ☐ Yes | ☐ No |

☐ Other_____

PLACE PATIENT LABEL HERE

| | | | | |
|---|---|---|---|---|
| Down Syndrome | □ Yes | _____ | □ No | □ Don't Know |
| Other Chromosome defects | □ Yes | _____ | □ No | □ Don't Know |
| Marfan Syndrome | □ Yes | _____ | □ No | □ Don't Know |
| Hemophilia | □ Yes | _____ | □ No | □ Don't Know |
| Sickle Cell Anemia | □ Yes | _____ | □ No | □ Don't Know |
| Thalassemia | □ Yes | _____ | □ No | □ Don't Know |
| Galactosemia | □ Yes | _____ | □ No | □ Don't Know |
| Deafness/Blindness | □ Yes | _____ | □ No | □ Don't Know |
| Color Blindness | □ Yes | _____ | □ No | □ Don't Know |
| Hemochromatosis | □ Yes | _____ | □ No | □ Don't Know |

□ Other-Specify _____

**Emotional Status:** Please rate on a scale of 1-10 (1 is best and 10 is worst)

How do you estimate your average level of stress to be? 1 2 3 4 5 6 7 8 9 10
Over the last two weeks have you felt little pleasure in doing things?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Over the last two weeks have you felt down, depressed or hopeless?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Do you see a counselor? □ **No** □Yes- for how long? _____ How often?_____ Name of counselor: _____
Do you feel safe at home? ❑**Yes** ❑No

**Vaccinations**:

| | | | |
|---|---|---|---|
| Chickenpox (Varicella) | □ No | □ **Yes** (dates _____) | □ Don't know |
| MMR-Measles, Mumps and Rubella | □ No | □ **Yes** (dates _____) | □ Don't know |
| BCG (Tuberculosis) | □ No | □ **Yes** (dates _____) | □ Don't know |
| Hepatitis B | □ No | □ **Yes** (dates _____) | □ Don't know |
| Polio | □ No | □ **Yes** (dates _____) | □ Don't know |
| Hepatitis A | □ No | □ **Yes** (dates _____) | □ Don't know |
| Tetanus | □ No | □ **Yes** (dates _____) | □ Don't know |
| Influenza | □ No | □ **Yes** (dates _____) | □ Don't know |
| Human papilloma virus (HPV) | □ No | □ **Yes** (dates _____) | □ Don't know |

**Prior Fertility Testing and Treatment**:

□ Have you had prior fertility testing or treatment ? □ **No** □ Yes

**Prior Tests**: (check all that apply): □ **None**

□ Basal body temperature chart (date_____/results_____)
□ Thyroid blood test (date_____/results_____)
□ Ovulation test kit (date_____/results_____)
□ Day 3 blood test FSH level (date_____/results_____)
□ AMH blood test (date_____/results_____)
□ Prolactin blood test (date_____/results_____)
□ Hysterosalpingogram (date_____/results_____)

☐ Laparoscopy surgery (date_____/results_____)
☐ Hysteroscopy surgery (date_____/results_____)
☐ Semen analysis (date_____/results_____)

Prior fertility treatment:_____
_____
_____

Additional information:_____
_____
_____

| PATIENT SIGNATURE | PRINT NAME | DATE | TIME |
|---|---|---|---|
| | | | |

I confirm that I have reviewed the information above.

| PROVIDER SIGNATURE | PRINT NAME AND TITLE | DATE | TIME |
|---|---|---|---|
| | | | |

PLACE PATIENT LABEL HERE