**New Patient Medical Intake Form**

This form helps us learn about your medical history. Please complete it to the best of your ability. 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):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Patient</th>
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### Medical History

**What medical conditions do you have?**

- □ Diabetes Type I
- □ Diabetes Type II
- □ High Blood Pressure/Hypertension
- □ High Cholesterol
- □ Heart Disease
- □ History of Stroke
- □ History of Heart Attack
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ Liver Disease
- □ Pancreatitis
- □ Kidney Disease
- □ Breast Disease
- □ Other medical conditions not listed:

- □ Thyroid Disease
- □ Migraines
- □ Blood clots
- □ Chronic Pain
- □ Arthritis
- □ Osteoporosis
- □ Autoimmune Disease
- □ Epilepsy
- □ Traumatic Brain Injury
- □ Pituitary Adenoma
- □ Alzheimer’s or Dementia
- □ Hearing Impairment
- □ Blindness
- □ Intersex Condition

**Sleep Apnea**

- □ None

**(Skip this section)**

**Other medical conditions not listed:**

- □ Allergies
- □ Asthma
- □ COPD or Emphysema
- □ Tuberculosis (TB)
- □ Cancer
- □ HIV or AIDS
- □ HSV (Herpes)
- □ Endometriosis
- □ Fibroids
- □ Polycystic Ovarian Syndrome (PCOS)
- □ Incontinence
- □ Hemorrhoids
- □ Irritable Bowel Syndrome

### Mental Health History

**What mental health conditions do you have?**

- □ Depression
- □ Anxiety
- □ PTSD
- □ Bipolar I
- □ Bipolar II
- □ Obsessive Compulsive Disorder
- □ Other mental health conditions not listed:

- □ Schizoaffective Disorder
- □ ADD/ADHD
- □ Autism Spectrum Disorder
- □ Eating Disorder
- □ Substance Use Disorder (sober or currently using)
- □ Alcoholism (sober or currently using)

**Other mental health conditions not listed:**

- □ None

**(Skip this section)**

### Allergies

**What are your allergies and what is your reaction?**

- □ Medications
- □ Foods
- □ Animals/Insects

- □ 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)?

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How often?</th>
<th>What is it for?</th>
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</tbody>
</table>

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

**Medical History of Blood Relatives**

To your knowledge, have any of your blood relatives had any of the following? If so, please indicate who of your blood relatives has the condition.

☐ None  ☐ Unknown  (Skip this section)

- Diabetes
- High Cholesterol
- High Blood Pressure
- Heart Attack
- Stroke
- Heart Surgery
- Thalassemia
- Not Listed:

☐ None  ☐ Unknown  (Skip this section)

- Sickle Cell Anemia
- Osteoporosis
- Parkinson’s Disease
- Alzheimer’s Disease
- Mental health issues
- Alcoholism
- Drug User
- Thyroid Condition

**Surgical History**

What surgeries have you had in the past and in what year?

☐ None  (Skip this section)

- Appendix removal
- Tonsils removal
- Hernia repair
- Gall bladder removal
- Orthopedic
- Breast lumpectomy
- Unilateral mastectomy
- Not Listed:

- Breast Reduction
- Bilateral Mastectomy
- Hysterectomy
- Oophorectomy
- Metoidioplasty
- Phalloplasty
- Scrotoplasty
- Body Contouring
- Breast Implants
- Orchietomy
- Vulvoplasty
- Vaginoplasty
- Tracheal Shave
- Facial Surgery

Have you ever injected or pumped silicone, oils, or other substances for the purpose of body shaping?  
☐ Yes  ☐ No

**Hospitalizations**

Other than for surgery or childbirth, have you ever been hospitalized overnight for a medical or mental health issue?  
☐ Yes  ☐ No

If yes, what for and when?

________________________________________________________

________________________________________________________

________________________________________________________
Date: __________________

Name (to be called) _________________________________ Name Listed with Insurance (if different): _________________________________

Pronoun _____________________ Birthdate ____________________

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### Vaccinations

**Have you received childhood vaccinations?**
- [ ] No
- [ ] I’m not sure
- [ ] Yes

**Have you been vaccinated for: Approximate Date**
- HPV (Gardasil)
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Tetanus / TdaP
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Hepatitis A
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Hepatitis B
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Influenza (Flu)
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Pneumonia (Pneumovax)
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Chicken pox (Varavax)
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Shingles (Zostavax)
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure
- Meningitis
  - [ ] No
  - [ ] Yes
  - [ ] I’m not sure

**When was the last time you had a test for tuberculosis (TB)?** ______________

**What was the result?**

- [ ] Yes
- [ ] No
- [ ] Unsure

**Have you ever had a positive test for TB?**
- [ ] Yes
- [ ] No
- [ ] Unsure

If yes, did you complete ≥ 6 months of preventative treatment?
- [ ] Yes
- [ ] No
- [ ] Unsure

**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 in the past 2 years?**
- [ ] 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 homelessness?**
- [ ] Yes
- [ ] No

**Are you a health care worker?**
- [ ] Yes
- [ ] No

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### Sexual Health & Cancer Screenings

**When was your last: Date Result**

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Pap Smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal Pap Smear</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>HIV Test</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>Sexually Transmitted Infection Test</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>Hepatitis C Test</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>Mammogram</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>Bone Density Scan</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td>Cholesterol Lab Test</td>
<td>never</td>
<td>unsure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Have you ever been diagnosed with or tested positive for a sexually transmitted infection?**

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: ____________________________
**What is your sexuality?** (Check all that apply)

- Lesbian
- Gay
- Bisexual
- Queer
- Pansexual
- Heterosexual (Straight)
- Not Listed: ______________________

**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
- Trans Feminine
- Non-Binary
- Cis-gender Men
- Trans Masculine
- 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)

How old were you when you first got your period?

- Unsure
- Yes
- No

(Skip this section)

Do you still have regular periods?

- Yes
- No

If no, are you on any medications that stop or affect your period (such as hormones)?

- Yes
- No

(Skip this section)

What was the date that your last normal period began?

Are you capable or have you ever been capable of becoming pregnant?

- Yes
- No

(Skip this section)

Have you ever been pregnant?

- Yes
- No

If yes, 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?

Are you planning on getting pregnant in the future?

- Yes
- No

Do you or your partner(s) use any kind of birth control?

- Not needed
- Yes

If yes, what kind?

Are you satisfied with this method?

- Yes
- No
**Have you or are you currently going through menopause?**

- Unsure
- Yes
- No

(Skip this section)

**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

**Have you ever been forced or pressured to have sex?**

- Yes
- No

**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
- Rx Opioids (Fentanyl, Codeine, Oxycontin, Vicodin, Percocet, Dilaudid, Morphine, etc)
- Heroin
- Cocaine/Crack
- Methamphetamines (Crystal Meth)
- Rx Stimulants (Ritalin, Adderall, Dexameth, Concerta, etc)
- Ketamine (Special K)
- Barbiturates (Phenobarbitol)
Name (to be called) _________________________________ Name Listed with Insurance (if different): ____________________________

Pronoun ____________________________  Birthdate ________________

☐ Cathinones (Bath Salts)  ☐ Sleeping Aids (Ambien, Lunesta, etc)  ☐ Not Applicable
☐ MDMA (Ecstasy)  ☐ Rohypnol (GHB)  ☐ No
☐ Phencyclidine (PCP)  ☐ LSD (Acid)  ☐ Thinking about Quitting
☐ Anabolic Steroids or Human Growth Hormone  ☐ Mushrooms  ☐ Yes
☐ Benzodiazepines (Xanax, Klonopin, Ativan, etc)  ☐ DMT (Ayahuasca)  ☐ Ready to Quit
☐ Nitrous Oxide (Whippets)  ☐ Peyote (Mescaline)  ☐ No
☐ Alkyl Nitrites (Poppers)  ☐ Not Listed: ____________________________

If you use opioids, do you have access to Narcan (Naloxone)?
☐ No  ☐ Thinking about Quitting  ☐ Ready to Quit

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? ______________________

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? ______________________

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?
☐ Yes  ☐ No

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?
☐ Yes  ☐ No

Do you floss daily?
☐ Yes  ☐ No

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 on disability for: ____________________________
☐ No, I’m unemployed
☐ Yes, I’m in school for: ____________________________
☐ No, I’m retired

What is your current living situation?
☐ House or Apartment (Stable/Permanent)  ☐ In a Residential Treatment Program  ☐ In a Vehicle
☐ 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?
☐ Yes  ☐ No

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
Date: __________________

Name (to be called) _________________________________ Name Listed with Insurance (if different): _________________________________

Pronoun _____________________ Birthdate ___________ ___________

Are there working smoke detectors in your home? □ No □ Yes
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

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

☐ Woman ☐ Man ☐ Trans ☐ Transgender ☐ Tomboy ☐ Non-Binary
☐ MTF ☐ FTM ☐ Transsexual ☐ Two-Spirit ☐ Hijra ☐ Bi-Gender
☐ Trans Feminine ☐ Trans Masculine ☐ Aggressive (AG) ☐ Hijra ☐ Kathoey ☐ Multi-Gender
☐ Transgender ☐ Feminine-of-Center ☐ Butch ☐ Muxe ☐ Trans Feminine ☐ Transgender
☐ Transgender ☐ Masculine-of-Center ☐ Stud ☐ Kathin ☐ Trans Feminine ☐ Transgender
☐ Transgender ☐ T-Girl ☐ Androgynous ☐ Gender Non-Conforming ☐ Trans Feminine ☐ Transgender
☐ Transgender ☐ T-Boy ☐ Demigirl ☐ Genderqueer ☐ Trans Feminine ☐ Transgender
☐ Transgender ☐ T-Boy ☐ Demiboy ☐ Gender Variant ☐ Trans Feminine ☐ Transgender
☐ Not Listed: ________________________________ ☐ Transgender ☐ Trans Feminine ☐ Transgender

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, non-binary, or gender non-conforming?
____________________________________________________________________________________________________

Have you changed your name and/or gender marker on all of your identity documents? □ No □ Yes

If no, do you want to update any of your identity documents? □ Yes □ No

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)________

Lyon-Martin Health Services & Women’s Community Clinic ◊ 1735 Mission Street ◊ San Francisco, CA 94103 ◊ (415) 565-7667
Date: ___________________  
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

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

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?
- Are you interested in starting or re-starting hormone therapy?
  - 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

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!