Today's Date: ______________________
(dd/mm/yyyy)

MEDICAL HISTORY INTAKE

Please fill out the following form to the best of your ability. Any information that you provide is confidential and will not be shared without your consent. Please be aware that disclosure of the abuse of a minor is reportable by law.

Name: ____ **Pronouns:** ________/__________
(First, Last) (she/her, he/him, they/them, etc.)

Legal Name: ______________________________________ **Date of Birth:** _____/_____/_____
(If different from above) (dd/mm/yyyy)

What is your gender?______________________________ **Health Card:** ____________________
(Please note if not an SK card)

Phone #: (_____)_______________ **Alternate #:** (_____)_______________ **Can we leave a message?** ☐ No ☐ Yes

Email:____ **Can we email you?** ☐ No ☐ Yes

ALLERGIES

Do you have any allergies, including to any drug, medication, environmental, or latex?

☐ No ☐ Yes

If you answered yes, please write the allergy and type of reaction:

____

MEDICATIONS

List all medications or drugs you are now taking or take often, including prescriptions, over-the-counter, herbal, vitamins, minerals, or supplements:

____

MEDICAL HISTORY

Check if you have current or past medical conditions ☐ No medical conditions

☐ Anemia
☐ Bleeding/Clotting Disorder
☐ DVT/Blood Clot in Legs/Lungs
☐ Heart Attack/Stroke
☐ High Blood Pressure
☐ Depression/Mood Disorder
☐ Diabetes
☐ Drugs/Alcohol Abuse
☐ Lupus
☐ Migraine

☐ Osteoporosis
☐ Thyroid Disease
☐ Liver/Kidney/Gallbladder
☐ Endometriosis
☐ Fibroid Uterus
☐ Genital Herpes
☐ Genital Warts
☐ Gonorrhea/Chlamydia
☐ Syphilis
☐ Hepatitis A/B/C

☐ HIV/AIDS
☐ Infertility
☐ Pelvic Inflammatory Disease
☐ PCOS
☐ Vaginitis, recurrent
☐ Breast Cancer
☐ Cancer: Cervical
☐ Cancer: Ovarian
☐ Cancer: Uterine
☐ Cancer: Other

☐ Any other conditions? ____

☐ Any surgeries? ____

This form is double sided!

ORGAN INVENTORY

Why do we ask about this? We do not want to make any assumptions about your body or identity. Asking about your physical characteristics helps us provide the best care possible by listening to you as the expert on your body.

Please check all that apply:

Breasts: ☐ Present ☐ Absent
☐ Chest reconstruction
☐ Both breasts removed
☐ Right breast removed
☐ Left breast removed
☐ Breast implants/Augmentation

Uterus: ☐ Present ☐ Absent
☐ hysterectomy & cervix removed
☐ hysterectomy & cervix remains

Vagina: ☐ Present ☐ Absent
☐ Vaginoplasty; vagina construction/modification
☐ Colpocleisis; closure of the vagina

Cervix: ☐ Present ☐ Absent

Ovaries: ☐ Present ☐ Absent
☐ Both ovaries removed
☐ Right ovary removed
☐ Left ovary removed

Urethra: ☐ Present ☐ Absent
☐ Urethral lengthening

Prostate: ☐ Present ☐ Absent
☐ Prostatectomy; partial/complete removal of prostate

Testes: ☐ Present ☐ Absent
☐ Testicular implants
☐ Both testicles removed
☐ Right testicle removed
☐ Left testicle removed

Penis: ☐ Present ☐ Absent
☐ Phalloplasty; penis construction/modification
☐ Metoidioplasty; creation of penis using clitoris
☐ Erectile device
☐ Penectomy; removal of penis

ANYTHING ELSE?

Is there anything we should know about you to help make your experience more comfortable? You may wish to disclose any accommodations you require like mobility requirements, mental health concerns, or other support needs. We are also happy to provide a chaperone to attend your appointment with you if you are uncomfortable attending alone. Please make any notes in the space below:

____

____

____

____

If you have experienced sexual, physical or emotional abuse and would like to talk to someone about it, please let your practitioner know so they can offer support.

By signing this form, I acknowledge that I have completed it to the best of my knowledge.

Patient Signature: ______________________________ **Date:** ____________________