**PLEASE PRINT**

**Florida Department of Health, Hernando County Medical History Form**

**Allergies of Any Kind** (drugs, pets, foods, chemicals)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Past Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you, or have you ever had, any of the following? | Yes | No | If Yes, List Specific Problem and Date First Diagnosed if Known |
| ADD/ADHD |  |  |  |
| AIDS/HIV |  |  |  |
| Asthma/Lung Disease |  |  |  |
| Alzheimer or Dementia |  |  |  |
| Anemia/Blood Disorder/Sickle Cell Disease or Trait |  |  |  |
| Birth Defect/Genetic Problem |  |  |  |
| Received Blood or Blood Products |  |  |  |
| Bone or Joint Problems |  |  |  |
| Bruise Easily or Excessive Bleeding |  |  |  |
| Cancer |  |  |  |
| Chronic Pain |  |  |  |
| Diabetes |  |  |  |
| Eye, Ear, Nose or Throat Problem |  |  |  |
| Fainting Spells or Frequent Dizziness |  |  |  |
| GI/Reflux/Stomach or Bowl Problems |  |  |  |
| Headache-Severe or Migraine |  |  |  |
| Heart Disease or Attack |  |  |  |
| High Blood Pressure |  |  |  |
| High Cholesterol |  |  |  |
| Kidney Disease or Bladder Problems |  |  |  |
| Liver or Gallbladder Problems |  |  |  |
| Mental Illness, Emotional Problems |  |  |  |
| Seizure Disorder or Epilepsy |  |  |  |
| Skin Problems |  |  |  |
| Stroke |  |  |  |
| Thyroid/Endocrine Disorder |  |  |  |

**Family Medical History**

**Father:** \_\_\_ Living\_\_\_\_ Deceased\_\_\_\_ Unknown **Mother:** \_\_\_\_ Living\_\_\_\_ Deceased\_\_\_\_ Unknown

If deceased list age and cause of death: (ex. Lung cancer, heart attack, stroke) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any known diseases that you know your father or mother had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Surgeries and Hospitalizations**

List any surgeries you have had and the year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List any significant Injuries you have had that required treatment and date(s):**

**List any hospitalizations where you were in the hospital for longer than 24 hours; give the reason(s) and date(s):**

**List all medications you are taking: (use the back of the form if needed)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dates of Immunizations:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Up to date \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_\_ Unknown

**Reproductive Life Plan**

Have you ever thought about having children or more children? \_\_\_\_\_Yes \_\_\_\_\_ No \_\_\_\_\_Undecided

If yes/undecided:

Have you thought about how many children you would like to have? \_\_\_\_\_1\_\_\_\_\_2\_\_\_\_\_3 or more\_\_\_\_\_ Not Sure

Are you interested in getting pregnant or starting a family? \_\_\_\_\_within the next year\_\_\_\_\_\_ 1-3 years \_\_\_\_\_more than 3 years

If no:

How important is it to you to prevent pregnancy? \_\_\_\_\_ Not sure/I don’t want to be pregnant now/I don’t want to get someone pregnant\_\_\_\_\_ Important (want to wait 1-2 years) \_\_\_\_\_ Very important (want to wait 3 or more years) \_\_\_\_\_ Very important (want permanent protection)

Are you currently using a birth control method? \_\_\_\_ Yes \_\_\_\_ No

If yes, list method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with your method? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you feel that you: Use your birth control consistently? \_\_\_\_\_ Always\_\_\_\_\_ Sometimes\_\_\_\_\_ Never

Do you feel you use your birth control correctly? \_\_\_\_\_ Always\_\_\_\_\_ Sometimes\_\_\_\_\_ Never

**Female Patients**

Menstrual History:

Age of onset for 1st period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of 1st day of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Periods come every \_\_\_\_\_\_ days and last \_\_\_\_\_ days.

Menstrual Periods are: \_\_\_\_ Regular \_\_\_\_ Irregular If irregular, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menstrual pain: \_\_\_None \_\_\_ Mild \_\_\_\_ Moderate \_\_\_\_ Severe

Do you have bleeding between periods? \_\_ Yes\_\_\_ No

Menopause? \_\_\_\_ Yes\_\_\_\_ No If yes, age at Menopause \_\_\_\_\_\_ Hormone Replacement? \_\_\_\_ Yes \_\_\_\_ No

Do you perform self-breast exams? \_\_\_\_ Yes\_\_\_\_ No Have you ever had a mammogram? \_\_\_\_ Yes\_\_\_\_ No

Date of Last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had an abnormal mammogram? \_\_\_\_ Yes \_\_\_\_ No

If yes, list date and describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Date of last Pelvic Exam: \_\_\_\_\_\_\_\_ Last PAP Exam: \_\_\_\_\_\_\_\_Have you ever had an abnormal PAP? \_\_\_\_Yes \_\_\_\_ No

Have you ever had an abnormal HPV Test? \_\_\_\_ Yes\_\_\_\_ No

If yes to either PAP or HPV list date and treatment if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy History**

Number of times pregnant\_\_\_\_\_ Age at first pregnancy \_\_\_\_\_

Number of full terms births\_\_\_\_\_ Number of stillbirths\_\_\_\_\_

Number of pre-term births\_\_\_\_\_ Number of c-sections\_\_\_\_\_

Number of spontaneous abortions (miscarriages) \_\_\_\_\_Number of ectopic pregnancies \_\_\_\_\_

Number of induced abortions \_\_\_\_\_

Number of living children\_\_\_\_\_

How long ago was your last pregnancy \_\_\_\_\_ years \_\_\_\_\_months

Other pregnancy comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**All Patients answer the rest of the History Questions**

**Safety**

Do you use seatbelts when driving or riding in a vehicle? \_\_\_\_\_ Yes \_\_\_\_\_ Sometimes \_\_\_\_\_ No \_\_\_\_\_ Rarely \_\_\_\_\_ NA

Are children and other passengers properly restrained when riding with you? \_\_\_\_\_ Yes \_\_\_\_\_ Sometimes \_\_\_\_\_ No \_\_\_\_\_ Rarely \_\_\_\_\_ NA

Do you wear a helmet when riding a motorcycle or bicycle? \_\_\_\_\_ Yes \_\_\_\_\_ Sometimes \_\_\_\_\_ No \_\_\_\_\_ Rarely \_\_\_\_\_ NA

Are you exposed to any hazardous substances at home or work?

\_\_\_\_\_ No\_\_\_\_\_ Yes; name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use**:

A drink is defined as 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of spirits

How often do you have a drink containing alcohol?

\_\_\_\_\_Never \_\_\_\_\_Monthly or less \_\_\_\_\_2-4 times a month\_\_\_\_\_\_\_\_\_\_\_\_2-3 times a week\_\_\_\_\_4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

\_\_\_\_\_ 1 or 2 \_\_\_\_\_3 or 4 \_\_\_\_\_5 or 6 \_\_\_\_\_\_7 to 9 \_\_\_\_\_10 or more

How often do you have five or more drinks on one occasion?

\_\_\_\_\_ Never \_\_\_\_\_ Less than monthly \_\_\_\_\_ Monthly \_\_\_\_\_ Weekly \_\_\_\_\_ Daily or almost daily

How many times in the past year have youused an illegal drug or used a prescription medication for non-medical reasons? \_\_\_\_\_\_\_\_\_\_\_

Do you or have you ever smoked cigarettes or used tobacco or nicotine products? \_\_\_\_ Yes\_\_\_\_ No

If yes, indicate products: Cigarettes \_\_\_\_\_Packs per day\_\_\_\_ E-cigs \_\_\_\_ Pipe \_\_\_\_

Hookah \_\_\_\_ Dip \_\_\_\_ Clove Cigs\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what age did you start using tobacco products? \_\_\_\_\_\_

What is your current smoking status?

\_\_\_\_ Never Smoker (no more than 100 cigs in a lifetime)

\_\_\_\_ Former Smoker (more than 100 cigs in a lifetime but not current smoker)

\_\_\_\_ Current Some Day Smoker (at least 100 cigs in lifetime + still smoking periodically)

\_\_\_\_ Current Every Day Smoker (at least 100 cigs in lifetime + smoking currently every day)

\_\_\_\_ Heavy Smoker (greater than 10 cigs per day)

\_\_\_\_ Light Smoker (less than 10 cigs per day)

Would you like a referral to help you with your tobacco use habit? \_\_\_\_ Yes\_\_\_\_ No

**All Patients answer the rest of the History Questions**

**Sexual History**

Are you currently sexually active? \_\_\_\_\_ Yes\_\_\_\_\_ No

Have you ever been sexually active? \_\_\_\_\_ Yes\_\_\_\_\_ No

\_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_ Both

In the last ***2 months***, how many sexual partners (including casual/ one-night stands) have you had?

Total \_\_\_\_\_\_Male \_\_\_\_\_\_Female \_\_\_\_\_\_

In the last ***12 months***, how many sexual partners (including casual/ one-night stands) have you had?

Total \_\_\_\_\_\_Male \_\_\_\_\_\_Female \_\_\_\_\_\_

Circle the types of sex you have had: Vaginal Oral Rectal

Have you ever injected drugs? \_\_\_\_\_ Yes\_\_\_\_\_ No

Have you ever had sex with someone who injected drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No\_\_\_\_\_ Unknown

Have you ever exchanged money or drugs for sex? \_\_\_\_\_ Yes\_\_\_\_\_ No

Have you ever had sex with someone who exchanged money or drugs for sex?

\_\_\_\_\_ Yes\_\_\_\_\_ No\_\_\_\_\_ Unknown

What are you or your partner(s) doing to protect yourself against STD’s and HIV? \_\_\_\_\_ Male condoms \_\_\_\_\_\_ Female condoms \_\_\_\_\_ Dental dam \_\_\_\_\_ Other \_\_\_\_\_ None

Do you use them all the time? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you use them correctly all the time? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever been diagnosed with a Sexually Transmitted Disease? \_\_\_\_\_ Yes\_\_\_\_\_ No

If yes: Check which disease, number of times diagnosed and date of last diagnosis.

|  |  |  |
| --- | --- | --- |
| **STD Diagnosis** | Number of times Diagnosed | Date of Most Recent Diagnosis |
| Gonorrhea |  |  |
| Chlamydia |  |  |
| Syphilis |  |  |
| Herpes |  |  |
| HPV |  |  |
| Pelvic Inflammatory Disease (PID) |  |  |
| Bacterial Vaginosis (BV) |  |  |
| Trichomoniasis |  |  |

Have you ever been tested for HIV? \_\_\_\_\_ Yes\_\_\_\_\_ No

Date of last test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result of last test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If HIV positive, please complete following section:**

\_\_\_\_\_ HIV positive, not AIDS \_\_\_\_\_ HIV positive; AIDS status unknown \_\_\_\_\_CDC defined AIDS

HIV/AIDS diagnosis Date of initial HIV positive test \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Not sure

Date of AIDS diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Not sure

Proof of positive/RW eligibility HIV test: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Not sure

HIV/AIDS diagnosis comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Medical Care for HIV? \_\_\_\_\_ Yes \_\_\_\_\_ No

Comments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exam Dates

Date of last physical exam \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Not sure

Comments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental exam\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Not sure

Comments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of AIDS-defining conditions

\_\_\_\_\_ CD4 cell count less than 200 cells/mm3 for millimeter cubed

\_\_\_\_\_ CD4% less than 14%

\_\_\_\_\_ Bacterial infections, multiple or recurrent

\_\_\_\_\_ Candidiasis of bronchi, trachea, esophagus, or lung

\_\_\_\_\_ Cervical cancer, invasive

\_\_\_\_\_ Coccidiomycosis, disseminated or extrapulmonary

**All Patients answer the rest of the History Questions**

Do you regularly eat 5 or more fruits & vegetables per day?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Do you regularly spend 2 or more hrs./day in recreation screen use (TV, video games, computer)?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Do you regularly get at least one hour of moderate physical activity a day?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Do you regularly limit consumption of sugary drinks?

\_\_\_\_\_ Yes \_\_\_\_\_ No

**All Patients answer the rest of the History Questions**

**Domestic violence, sexual assault, and human trafficking:**

Have you been physically hurt (hit, pushed, shoved, burned, slapped, and/or bitten), insulted, or threatened

(to take away income, children, and/or pets) by your loved one, partner or significant other?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Refuse to answer \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been touched sexually against your will or without your consent?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Refuse to answer \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is anyone forcing you to do work that you do not want to do (have you been threatened or denied to come

and go as you please)?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Refuse to answer \_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Answering these questions will help us to take better care of you.**

**Sexual Orientation**

Do you think of yourself as:

\_\_\_\_\_ Lesbian, Gay, or Homosexual \_\_\_\_\_ Straight or Heterosexual \_\_\_\_\_ Bisexual

\_\_\_\_\_ Something else, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Don’t know \_\_\_\_\_ Choose not to disclose \_\_\_\_\_ Pansexual (gender blind of omnisexual)

**Gender Identity**

Do you think of yourself as:

\_\_\_\_\_ Male

\_\_\_\_\_ Female

\_\_\_\_\_ Male to Female (MTF) Transgender Female/Trans Woman

\_\_\_\_\_ Female to Male (FTM) Transgender Male/Trans Man

\_\_\_\_\_ Genderqueer (neither exclusively male nor female)

\_\_\_\_\_ Additional category/Other

\_\_\_\_\_ Choose not to disclose

What sex were you assigned at birth? \_\_\_\_\_ Male \_\_\_\_\_ Female

Additional comments or information we should know to better partner with you to improve your health.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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