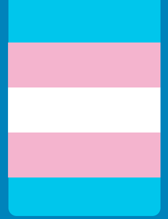
GENDER PATHWAYS CLINIC

AT KAISER PERMANENTE



Welcome to the Gender Pathways Clinic! Thank you for taking the time to fill out this form to help us provide the best possible care for you.

What name would you like us to use?: ______________________________

Medical Record Number (MRN): ______________________________

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: ______________________________

What is your current gender identity? ______________________________

What was your sex recorded at birth? ______________________________

Legal Name if differs from preferred/chosen name: ______________________________

If your current name/gender marker is different than your legal records, would you like assistance in legally changing your name/gender marker? ☐ No ☐ Yes

HORMONE HISTORY AND GOALS

Are you currently taking gender affirming hormones? ☐ No ☐ Yes

If **YES,** when did you start? ______________________________

What is your current dose and frequency: ______________________________

Have you experienced any negative effects from hormones? ☐ No ☐ Yes ______________________________

If you are **NOT** currently taking hormones, are you interested in starting hormones? ☐ No ☐ Yes

What questions or concerns do you have about starting hormones?

____

SURGICAL HISTORY AND GOALS

Have you had any gender affirming surgeries/treatments in the past?

☐ No ☐ Yes (which ones?) ______________________________

Do you wish to have future surgeries/treatments?

☐ No ☐ Yes (which ones?) ______________________________

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HEALTH HISTORY

Have you ever been diagnosed with any of the following medical conditions?

☐ Heart disease ☐ Diabetes

☐ Liver disease ☐ Tobacco/Nicotine use

☐ High cholesterol ☐ Overweight/Obesity

☐ High blood pressure ☐ Cancer/History of Cancer

☐ Migraine headaches ☐ Seizure disorder/Epilepsy

☐ Eating disorder ☐ Blood clots (in the lung, leg or elsewhere)

Have you been diagnosed with any of the following conditions?

☐ Klinefelter syndrome ☐ Congenital adrenal hyperplasia ☐ Intersex condition

Do you have or had a history of the following mental health conditions:

☐ Depression ☐ Suicide attempt/Self harm

☐ Anxiety ☐ Bipolar disorder/Schizophrenia

☐ PTSD ☐ Hospitalizations for any mental health conditions/suicide attempt

Are you currently seeing a therapist?

If YES, where? ______________________ **If NO,** would you like to? ☐ No ☐ Yes

Are you looking for an affirming primary care clinician?

☐ No, I already have one ☐ Yes, I'd like a list of local providers

Do you live with anyone? ☐ No ☐ Yes, with: ____

Is your current living situation safe? ☐ No ☐ Yes

Are your currently in school and/or working? ☐ No ☐ Yes, at: ____

Do you feel safe in your current school/work place? ☐ No ☐ Yes

Have you ever experienced any form of physical, verbal, or sexual abuse in the past? ☐ No ☐ Yes

If YES, are you currently safe from this abuse? ☐ No ☐ Yes

Is there anything you'd like us to do or avoid doing so as to provide better trauma informed care? ☐ No ☐ Yes

If YES, please explain: ____

Are you concerned about finances, housing, or access to food? ☐ No ☐ Yes

Do you currently use tobacco/nicotine products? ☐ No ☐ Yes

If YES, how much do you use per day? ____________________

Do you currently drink alcohol? ☐ No ☐ Yes

If YES, how many drinks do you have per week? ____________________

Do you currently use cannabis? ☐ No ☐ Yes

If **YES,** how do you use it and how often? ____________________

Do you currently use any other substances/drugs? ☐ No ☐ Yes

If **YES,** which ones and how regularly do you use them? ____________________

Have you used any other substances/drugs in the past? ☐ No ☐ Yes

If **YES,** which ones and how regularly did you use them? ____________________

Have you ever injected anything that was not prescribed by a doctor? ☐ No ☐ Yes

FAMILY HISTORY

Does anyone in your **immediate** family (parents, siblings) have any of these conditions?

☐ Heart Disease or Stroke

☐ Cancers

☐ Blood Clot Problems (DVT, PE)

☐ High Blood Pressure

☐ High Cholesterol

☐ Diabetes

SEXUAL HISTORY

Are you sexually active? ☐ No ☐ Yes

Are you sexually active with more than one partner, or have you been in the past 6 months? ☐ No ☐ Yes

Are you currently sexually active with someone with a uterus? ☐ No ☐ Yes

Are you currently sexually active with someone who produces sperm? ☐ No ☐ Yes

What parts of your body are involved during sex: ☐ Mouth ☐ Genitals ☐ Anus

Do you use barrier protection (e.g., condoms) against sexually transmitted infections (STIs)?

☐ All the time ☐ Sometimes ☐ No

Would you like STI testing today? ☐ No ☐ Yes

The sex that was recorded at birth for you (select one): ☐ Female ☐ Male

FOR SEX RECORDED FEMALE AT BIRTH

Do you bind your chest? ☐ No ☐ Yes

If **YES,** do you experience pain, rash, shortness of breath, or other symptoms? ☐ No ☐ Yes

Would you like more information about binding? ☐ No ☐ Yes

Are you having regular menstrual cycles (every 21–35 days)? ☐ No ☐ Yes

When was your last cycle? ____________ Do your cycles cause dysphoria? ☐ No ☐ Yes

Are you currently using birth control? ☐ No ☐ Yes

If **YES,** what are you using? ☐ IUD ☐ Pills ☐ Implant ☐ Shots ☐ Patch ☐ Ring ☐ Condom

Have you had a pap smear in the past? ☐ No ☐ Yes, my last exam was: ________________________________

Have you ever had an abnormal pap smear? ☐ No ☐ Yes

Have you had a mammogram? ☐ No ☐ Yes, my last exam was: ________________________________

Are you currently pregnant or chest feeding? ☐ No ☐ Yes

Do you plan/want to have a genetically similar child in the future? ☐ No ☐ Yes

Would you like to receive information about fertility preservation? ☐ No ☐ Yes

FOR SEX RECORDED MALE AT BIRTH

Is having an erect penis important to your sexual wellbeing? ☐ No ☐ Yes

Do you tuck/compress your genitals? ☐ No ☐ Yes

If **YES,** how/what do you use? ________________________________

Do you experience pain, rash or other symptoms? ________________________________

Would you like more info about tucking? ☐ No ☐ Yes

Do you plan/want to have genetically similar children in the future? ☐ No ☐ Yes

Would you like to receive information about fertility preservation? ☐ No ☐ Yes

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Staff: Scan to medical records