# **Keelee J. MacPhee, MD Plastic & Reconstructive Surgery GENDER DIVERSITY**

**Medical Intake Form – 2 pages** Please **Circle** where appropriate. Visit Date:\_\_\_\_\_\_\_\_\_\_\_

Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age/DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex Assigned at Birth:\_\_\_\_\_\_\_\_\_\_\_ Gender Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race:\_\_\_\_\_\_\_\_\_\_

Primary Care MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endocrine/Hormone Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transition start date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Time Life Experience Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormone start date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: Prescriptions, vitamins, herbs, home remedies. Please list Aspirin and Blood Thinners.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | dose | times/day | Medication | dose | times/day |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
| Allergies to medicine/food/other agent | reaction or side effect |
|  |  |
|  |  |

|  |
| --- |
| Medical History: |
|  |
|  |
|  |

|  |
| --- |
| Surgical History: |
|  |
|  |
|  |

Family History: High Blood Pressure, Diabetes, Heart Disease, Clots/DVT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Breast Cancer/Prostate Cancer: No/Yes: Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married, Divorced, Single, Widow, Separated, Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment: Full Time, Part Time, Disabled, Retired, Student, Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used tobacco? VAPE or E-cigarette? No/Yes Quit date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol consumption? No/Yes: Beer/Wine/Liquor: Amount per week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? Marijuana? No/Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV status: Positive/Negative/Unknown Date of HIV test:\_\_\_\_\_\_

Height:\_\_\_\_\_\_ Weight:\_\_\_\_\_\_ Weight Loss?\_\_\_\_\_\_\_\_\_\_ Regular Exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies:\_\_\_\_\_\_ Currently pregnant? No/Yes Date of last pregnancy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bra Size:\_\_\_\_\_\_\_\_ Last Mammogram Date: \_\_\_\_\_results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any: nipple discharge/breast lump/ breast change? details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear a Binder: No/Yes? for how long? \_\_\_\_\_\_

Please Circle any problems that you have experienced within the past two years:

|  |  |  |  |
| --- | --- | --- | --- |
| Fatigue  Fevers  Headache  Sweats  Weight Change | Chronic cough  Bronchitis  Shortness of breath  Asthma  Pneumonia | UTI/bladder infection  Kidney Stones  Incontinence  Trouble urinating  Prostate problems | Osteoarthritis  Rheumatoid arthritis  Gout  Carpal Tunnel  Back pain |
| Stroke  Seizures  Head Injury  Nerve damage  Insomnia | Loss of hearing  Dizziness  Nose bleeding  Gum bleeding  Allergies | Diabetes  Thyroid disease  Hormone treatment  Anabolic Steroids  Appetite change | Skin Cancer  Rashes  Acne  Abnormal Mole  Nail changes |
| Glaucoma  Cataracts  Vision Surgery  Blurry vision | Menopause  Hot Flashes  Breast masses  Genital Infections | Depression  Anxiety  Hallucinations  Panic attack | Bleeding disorder  Easy Bruising  Aspirin use  Homeopathy |
| Liver disease  Kidney disease  Varicose veins  Leg swelling  Alternative medical treatments | Reflux  Hepatitis  Blood in stool  Diarrhea/constipation  Hernia/repair  Gall Bladder disease | Heart attack  Chest pain/angina  Heart murmur  Anemia  Transfusions  Phlebitis/ blood clots | Coumadin use  Blood transfusions  Integrative medicine treatments  Accutane use  Deep vein thrombosis |

The information provided is true and complete to the best of my knowledge.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form updated 5/19/2020