PLANNED PARENTHOOD OF GREATER TEXAS

HORMONE THERAPY HISTORY

PERSONAL INFORMATION

Last Name (on insurance) First Name MI	Preferred Name	Date

Gender Pronoun
☐ She ☐ He ☐ They ☐ _____

Sex assigned at birth
☐ Female ☐ Male ☐ Intersex

Do you think of yourself as
☐ Female-to-male (FTM)/transgender man ☐ Genderqueer/nonbinary
☐ Male-to-female (MTF)/transgender woman ☐ _____

What are you seeking today?
☐ Feminizing hormone therapy
☐ Masculinizing hormone therapy

What are your transition goals?

Are you currently on hormones?
☐ Yes (specify meds below) ☐ No

Have you consulted a mental health provider?*
☐ Yes, date: ☐ No

Select the body parts that you currently have
☐ Breasts ☐ Cervix ☐ Ovaries ☐ Penis ☐ Prostate ☐ Testes ☐ Uterus ☐ Vagina

Please describe any gender confirmation surgeries you have had, when you had them, and any complications you experienced.

Do you have a support system for your transition? ☐ Yes ☐ No
Who: _____

ALLERGIES

Are you allergic to any of the following?
☐ Castor oil ☐ Cottonseed oil ☐ Sesame oil
☐ Chlorobutanol anhydrous (chloral derivative)

Additional allergies

MEDICATIONS

List all medications you currently take, including hormones, supplements, and herbs; their dosages; and how long you've been on them.

FEMINIZING HORMONE THERAPY HISTORY

Complete this section only if you are seeking feminizing hormone therapy. If you check **yes** to any question, please explain in the notes section below. Check here if adopted: ☐

Do you…	Yes	No	Unsure
Want to cause pregnancy someday?	☐	☐	☐
Use tobacco?	☐	☐	☐
Have cardiovascular (heart) disease?	☐	☐	☐
Have a history or risk of blood clots?	☐	☐	☐
Have Type 2 diabetes?	☐	☐	☐
Have Hepatitis?	☐	☐	☐
Have hypertension?	☐	☐	☐
Have kidney disease?	☐	☐	☐
Have chronic or end-stage liver disease?	☐	☐	☐
Have a pituitary gland tumor?	☐	☐	☐
Have hyperkalemia (high potassium level)?	☐	☐	☐
Have a personal or family history of estrogen-sensitive tumors?	☐	☐	☐
Get migraines with auras?	☐	☐	☐
Have a history of psychiatric disorders?	☐	☐	☐
Have family history of breast cancer?	☐	☐	☐
Have a sedentary lifestyle?	☐	☐	☐

MASCULINIZING HORMONE THERAPY HISTORY

Complete this section only if you are seeking masculinizing hormone therapy. If you check **yes** to any question, please explain in the notes section below. Check here if adopted: ☐

Do you…	Yes	No	Unsure
Take Warfarin (blood thinners)?	☐	☐	☐
Want to get pregnant someday?	☐	☐	☐
Know whether you're currently pregnant?	☐	☐	☐
Have cardiovascular (heart) disease?	☐	☐	☐
Have current or past vascular/ cerebrovascular disease?	☐	☐	☐
Have a history or risk of blood clots?	☐	☐	☐
Have Type 2 diabetes?	☐	☐	☐
Have hypertension?	☐	☐	☐
Have chronic or end-stage liver disease?	☐	☐	☐
Have PCOS?	☐	☐	☐
Have Hepatitis?	☐	☐	☐
Have polycythemia (increase in red blood cells)?	☐	☐	☐
Have a history of estrogen-sensitive tumors?	☐	☐	☐
Have a history of psychiatric disorders?	☐	☐	☐
Have family history of heart disease?	☐	☐	☐

NOTES

* PPGT may require a mental health provider consultation depending on patient history. This is **not** a requirement for all patients and will be determined on a case-by-case basis.