

Confidential Application

Legal Name _____

Preferred Name _____ SS# _____

DOB _____ Address _____

City _____ Zip _____

Country _____ State _____

Home Phone _____ Cell _____

E-mail _____ Occupation _____

Employer _____

Emergency Contact Name/Relationship _____

Emergency Contact # _____

Insurance Carrier _____

Address _____ City _____

Zip _____ Country _____ State _____

Phone _____ Fax _____ Plan _____

Expiry _____ ID# _____ Policy# _____

Subscriber's Name _____

ALLERGIES: _____

Primary Care Provider Info

Name & Title _____

Phone _____ Fax _____ Email _____

Address _____

List **ALL** Past and Present Medical Conditions

___Ulcer

___Diabetes

___Asthma or Wheezing

___Hernia

___Bleeding Disorder

___Cold Sores

___Tobacco Use

___Substance Abuse

___Heavy Snoring/Sleep Apnea

___High Blood Pressure

___Frequent Heartburn or Reflux

___Blood Clot

___Previous Hormone Use or Experimentation

___FtM Breast Binding

___Heart Murmur that has required medication

___Any Other Heart Problem_____

___Broken Bones_____

___Prostate or Urination Difficulty_____

___Sexually Transmitted Infection_____

___High Cholesterol or Triglycerides

Any other health problems not previously listed_____

List **ALL** Previous Surgeries/Surgeon/Year

List ANY Hospitalizations other than Surgery

List ANY Health Problems of Family Members

___Adopted

Mother _____

Is she living? _____ What is/was her age? _____

Father _____

Is he living? _____ What is/was his age? _____

Do any family members have a history of the following?

___Diabetes Which Relative? _____

___Stroke Which Relative? _____

___Prostate Cancer Which Relative? _____

___GLBT? Which Relative? _____

___Heart Attack Which Relative? _____

___Breast Cancer Which Relative? _____

___Psych Issues Which Relative? _____

___Abnormal Bleeding or Blood Clots Which Relative? _____

___Female Cancers (uterus, cervix, ovaries) Which Relative? _____

Health Maintenance Record

Please list the approximate date of any of the following tests you have had, as well as any abnormalities detected.

	<u>YEAR</u>	<u>RESULT</u>
<input type="checkbox"/> PAP smear	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> PSA (Prostate)	_____	_____
<input type="checkbox"/> Chest X-ray	_____	_____
<input type="checkbox"/> Pelvic Ultrasound	_____	_____
<input type="checkbox"/> Cholesterol	_____	_____
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Stress Test	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> Monthly Self Breast Exam		<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Rectal Exam	_____	_____
<input type="checkbox"/> HIV test	_____	_____
<input type="checkbox"/> Hepatitis C	_____	_____

Check if you take the following on a daily basis? Aspirin Multi-vitamin Calcium

Research and Mentoring

*Would you be willing to speak with other patients who are having a similar procedure/service to help them understand what to expect? (i.e. pain level, time for recovery, overall satisfaction) yes no

*May we use pictures of your surgery (not to include your face) on our website to help others understand post-operative outcomes? yes no

*May we include pictures of any facial surgery? yes no

*Under **complete anonymity**, may we use your patient data to further Trans-Research? yes no

I attest that all above information submitted in the previous 5 pages is accurate.

Print Legal Name

Legal Signature or X

Date