Papillon Center Intake Application

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CONFIDENTIAL APPLICATION

Please complete this form in its entirety

Legal Name _____

Preferred Name_____

DOB_____SS#_____

Address_____

City_____State_____

Zip_____Country_____

Home Phone_____Cell Phone_____

Email_____

Occupation_____Employer_____

Emergency Contact Name/Relationship_____

Emergency Contact #_____

Insurance Carrier _____

Address_____

City_____State_____

Zip_____Country_____

Phone Number_____Fax Number_____

Plan_____Policy#_____ID#_____

Subscriber's Name/Relation_____Expiry_____

PRIMARY CARE PROVIDER INFO

Name and Title _____

Phone Number_____Fax Number_____

Email_____

Address_____

City_____State_____Zip_____

List ALL Past and Present Medical Conditions

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol or Triglycerides
- ☐ Asthma or Wheezing
- ☐ Heavy snoring or Sleep Apnea
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Heart Murmur that required medication
- ☐ Frequent Heartburn or Reflux
- ☐ Ulcer
- ☐ Hernia
- ☐ Tobacco Use – Quit _____
- ☐ Substance Abuse
- ☐ Alcohol Abuse
- ☐ Any other Heart Problem_____
  _____
  _____
- ☐ Broken Bones_____
  _____
- ☐ Prostate or Urination Difficulty_____
  _____
  _____
- ☐ Urethral Stricture
- ☐ Incontinence_____
  _____
- ☐ Rectal Bleeding
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Sexually Transmitted Infections_____
  _____
- ☐ Cold Sores
- ☐ Psoriasis or Eczema
- ☐ Previous Hormone Use or Experimentation
- ☐ FtM Breast Binding
- ☐ Any other health problem not listed_____
  _____
  _____

List ALL Previous Surgeries. *Include name of Surgeon and Year*

_____
_____
_____
_____
_____
_____
_____

List ANY Hospitalizations other than for 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?_____
☐ Breast Cancer	Which Relative?_____
☐ Female Cancers (uterus, cervix, ovaries)	Which Relative?_____
☐ Heart Attack	Which Relative?_____
☐ Abnormal Bleeding or Blood Clots	Which Relative?_____
☐ Crohn's Disease or Ulcerative Colitis	Which Relative?_____
☐ Psoriasis	Which Relative?_____
☐ Psych Issues	Which Relative?_____

List ALL medications, hormones, vitamins that you are taking or have taken in the last two years

Drug	*Strength*	*Frequency*

GENDER HISTORY

Papillon Center Does Support the WPATH STANDARDS OF CARE

Primary Therapist Information

Name and Title _____

Phone Number_____Fax Number_____

Email_____

Address_____

City_____State_____Zip_____

Gender Counseling History

How many visits? _____Ongoing? _____

First visit date_____Last Visit date_____

Does your therapist have transgender counseling experience?_____

Real Life Experience

Full time?_____For how long?_____

Hormone History

Provider's information_____

_____

Does your Provider have experience in transgender hormone therapy?_____

Self Medicating?_____

List Hormonal Medications with start and stop dates (if applicable)_____

_____

_____

PATIENT INFORMATION

Age_____Height_____Weight_____BMI_____Do you smoke?_____

Weight and Height must be actual weight, not projected. We will weight you.

What services are you interested in? What month/year?_____

☐ Vaginoplasty	☐ Eyelid Surgery	☐ Voice Therapy referral
☐ Labiaplasty	☐ Face Lift	☐ Fertility referral
☐ Orchiectomy	☐ Rhinoplasty	☐ Revision Surgery
☐ Scrotoplasty	☐ Lip Lift/Facial Filler/Botox	☐ Workplace Seminar
☐ Facial Feminization	☐ Tracheal Shave	☐ Permanent Make-up/ Scar Camouflage
☐ Breast Augmentation	☐ Abdominoplasty	☐ Gender Counseling
☐ FtM Bottom Surgery	☐ Liposuction/Contouring	☐ Hormone therapy
☐ FtM Chest Surgery	☐ Electrolysis/Laser	☐ Other_____
☐ Hysterectomy referral		

HEALTH MAINTENANCE RECORD

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

	YEAR	RESULT
☐ PAP Smear	_____ ____	_____
☐ Mammogram	_____	_____
☐ PSA (Prostate)	_____	_____
☐ Chest X-ray	_____	_____
☐ Pelvic Ultrasound	_____	_____
☐ Cholesterol	_____	_____
☐ EKG	_____	_____
☐ Stress Test	_____	_____
☐ Colonoscopy	_____	_____
☐ Rectal Exam	_____	_____
☐ Monthly self-breast exams		☐ Yes ____No
☐ HIV Test	_____	_____
☐ Hepatitis C	_____	_____

☐ Check if you take the following on a daily basis: ____Aspirin____Multi-vitamin____Calcium ☐ Vit D

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

Initial intake submissions, emails, and/or telephone requests **do not establish a Doctor/Patient relationship** and should not be mistaken as such. This form is meant to expedite your appointment and will not be reviewed by Dr. McGinn until the time of your consultation. I attest that the information on this page and previous four pages is accurate.

Print legal name Legal Signature Date