GHC 6/27/2016

Patient Intake Form

Current Name:_____ **Date of Birth:**____/____/____ **Pronouns**: ____

Legal Name (name on your IDs):_____ Place of Birth (city, state, country):_____

If you are under 18 years old, what is/are the name(s) of your legal guardian(s):_____

Home Address:_____ **City/State:** _____ **Zip:**_____

_____

Mailing Address (if different):_____ **City/State:** _____ **Zip:**_____

_____

Phone Number:_____ **E-Mail:**_____

Can we leave you a confidential message at this phone number? Yes_____ No_____ **Emergency Contact:** Name:_____

Phone:_____

Relationship to you:_____

If you currently have health insurance, let the front desk know so we can make a copy of your card for GHC records.

Transgender Health History

At what age did you first first feel your gender identity did not match your physical body? _____

Have you felt depressed or suicidal because your gender identity does not match your body?

No _____ Yes _____

Are the following people supportive of your transition/gender expression?

Employer/School No _____ Yes _____ Family of Origin No _____ Yes _____

Friends No _____ Yes _____ Significant other No _____ Yes _____

Are you "out" at work/school? No _____ Yes _____

What are your fears if any about coming out or identifying as transgender?

_____

_____

Have you changed you gender on your identity documents? No _____ Yes _____

Have you ever discussed your gender identity with a healthcare provider? No _____ Yes _____

If Yes, what happened? _____

If No, why not? _____

Have you ever used transitioning hormones in the past? No _____ Yes _____

If Yes, 1) what hormones, 2) How Long? 3) Did you have any complications?

1) _____

2) _____

3) _____

Screening Tests/Immunizations:

When was your last:

Doctors visit: _____ Dental Cleaning: _____ Tetanus Booster: _____

Have you ever had a mammogram? No_____ Yes _____ I'm not sure _____

If Yes, when and where was your last one? _____

What was the result? Normal _____ Abnormal _____ I'm not sure _____

Have you ever had a pap smear (vaginal or rectal)? No _____ Yes _____ I'm not sure _____

If Yes, what were the results? Normal _____ Abnormal _____ I'm not sure _____

If abnormal, what was done? _____

If you are over 50, have you ever had a colon cancer screening? No _____ Yes _____ I'm not sure _____

If Yes, what were the results? Normal _____ Abnormal _____ I'm not sure _____

Medical History

What medical problems do you have now or have had in the past?

- ☐ None
- ☐ Blood Clots
- ☐ HIV/AIDS
- ☐ Asthma
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Breast Disease
- ☐ Allergies
- ☐ Migraines
- ☐ Heart Disease
- ☐ COPD
- ☐ Hepatitis C
- ☐ High Cholesterol
- ☐ Pancreatitis
- ☐ Emphysema
- ☐ Other Liver Problems
- ☐ High Blood Pressure
- ☐ Tuberculosis (TB)

Positive TB, Treated Y/N: _____

- ☐ Diabetes
- ☐ Cancer, what kind?_____
- ☐ Other:_____

Family History: Have any of your first degree relatives had any of the following problems?

- ☐ Blood Clots
- ☐ Clotting Disorder
- ☐ Heart Disease
- ☐ Stroke
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Uterine Cancer

What sexually transmitted infection(s) have you had in the past?

- ☐ None
- ☐ Gonorrhea, treated? Y/N:_____
- ☐ Syphilis, treated? Y/N:_____
- ☐ Genital Herpes
- ☐ Chlamydia, treated? Y/N:_____
- ☐ Trichomonas, treated? Y/N: _____
- ☐ Genital Warts
- ☐ Other_____

Hospitalization: Other than for surgery or childbirth, have you ever been in the hospital overnight?

Yes/No:_____ Why?_____

Surgical History: What operations have you had in the past?

- ☐ None
- ☐ Chest Reconstruction (top surgery)
- ☐ Silicon Injections
- ☐ Tonsillectomy
- ☐ Breast Augmentation (Implants)
- ☐ Vaginoplasty
- ☐ Gallbladder Removed
- ☐ Orchiectomy (removal of testes
- ☐ Phalloplasty
- ☐ Hernia Repaired
- ☐ Hysterectomy (removal of uterus
- ☐ Metoidioplasty
- ☐ Appendectomy
- ☐ Oophorectomy (removal of ovaries)

Which Relatives and what age?

_____

_____

_____

Social History

Are you raising children? No_____ Yes _____ How many? _____

Are you the main caretaker for parents/other adults? No _____ Yes _____ How many? _____

Do you feel safe in your home? No _____ Yes _____ Sometimes _____

Do you feel threatened, controlled or afraid of a family member, partner, or caregiver?

No _____ Yes _____ Sometimes _____

Who is your support system? Who do you talk to about your problems (feeling angry/sad/happy, etc? (check all that apply)

- ☐ Significant Other
- ☐ Friends
- ☐ Family of Origin
- ☐ Therapist
- ☐ Support Group
- ☐ Other: _____

Do you use tobacco now? No_____ Yes _____

If yes, what type and how much? _____

How old were you when you started? _____

Would you like to quit, if so when? _____

Would you like help quitting? No _____ Yes _____

Do you use marijuana? No _____ Yes _____

If Yes, how often? _____

Do you drink alcohol? No _____ Yes _____

If Yes, what type? _____

How often? _____

How much each time you drink? _____

Do you use any other drugs now? No _____ Yes _____

If Yes, what type(s) and how often? _____

Have you used any other drugs in the past? No _____ Yes _____

If Yes, what type? _____

When did you last use? _____

Have you spent time in prison or jail? No _____ Yes _____

Have you spent anytime in a shelter? No _____ Yes _____

Menstrual History

How old were you when you first got your period? _____

What was the date that your last normal period began? _____

Have your periods stopped due to hormone use or menopause? No _____ Yes _____

Have you had any bleeding since then? No _____ Yes _____

Have you ever been pregnant? No _____ Yes _____

If Yes, how many times have you been pregnant? _____

How many abortions? _____ How many premature births? _____

How many miscarriages? _____ How many full-term births? _____

How many children do you have now? _____

Are you planning to get pregnant? No_____ Yes _____

Do you use any kind of birth control? No _____ Yes _____

If Yes, what kind? _____

Sexual History

In your lifetime your sexual partner(s) have been: (check all that apply)

- ☐ None, I've never had sex
- ☐ Women
- ☐ Men
- ☐ Trans Women (MTF)
- ☐ Trans Men (FTM)
- ☐ Other: _____

Currently, your sexual partner(s) are: (check all that apply)

- ☐ None, not sexually active
- ☐ Women
- ☐ Men
- ☐ Trans Women (MTF)
- ☐ Trans Men (FTM)
- ☐ Other: _____

Currently how many sexual partners do you have? _____

Have you ever been hit, slapped, kicked or physically hurt by an intimate partner? No _____ Yes _____

If Yes, when did this happen? _____

Has anyone forced you to partake in sexual activities against your will? No _____ Yes _____

If Yes, when did this happen? _____

Have you ever exchanged sex for money, food, shelter, drugs or other things? No _____ Yes _____

If Yes, when did this happen? _____

Have you ever had sex while taking drugs other than marijuana or alcohol? No _____ Yes _____

If Yes, what drugs? _____

Are you having difficulties with your sex life? No _____ Yes _____

Do you want to discuss this today? No _____ Yes _____

Mental Health History

Are you currently receiving counseling? No _____ Yes _____

If Yes, where? _____

Have you been diagnosed by a doctor with any of the following?

☐	None	☐	Developmental Delay
☐	Depression	☐	Bipolar Disorder
☐	Anxiety	☐	Schizophrenia
☐	Asperger's	☐	Autism
		☐	Other: _____

Do you have the following symptoms?

☐	None	☐	Hallucinations
☐	Depressed Mood	☐	Panic Attacks
☐	Anxiety	☐	Thoughts of Suicide
☐	Suicide Attempts	☐	Racing Thoughts
		☐	Other: _____

Have you ever cut or intentionally hurt yourself? No _____ Yes _____

If Yes, when was the last time? _____

Have you ever tried to kill yourself? No _____ Yes _____

If Yes, when was the last time? _____

Do you have thoughts of killing yourself now? _____

Have you ever been hospitalized in a psychiatric hospital? No _____ Yes _____

If Yes, when and why? _____

Medications

Are you allergic to:	Medications/Latex	No _____	Yes _____	Which ones: _____
	Food/Nuts/Eggs	No _____	Yes _____	Which ones: _____

Please list the medications, vitamins, and herbs you take regularly:

_____

_____

Name, dose and how often you take the medication, what is the medication for?

_____

_____

MRN: _____ # Demographics

Today's Date: ____/____/_____ Zip Code : _____

Age Range: ☐ 12 or Under ☐ 13-17 ☐ 18-24 ☐ 25-35 ☐ 36-45 ☐ 46-55 ☐ 56-70 ☐ 71 or over

Gender Identity: (Check all that apply)
☐ Female ☐ Genderqueer ☐ Trans Man/FTM ☐ Trans Woman/MTF
☐ Queer ☐ Intersex ☐ Androgynous ☐ Agender
☐ Male ☐ Two-Spirit ☐ Unsure ☐ Non-Binary
My gender identity: _____

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Decline to state

Sexual Orientation: (Check all that apply)
☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Asexual
☐ Pansexual ☐ Queer ☐ Unsure ☐ Two-Spirit ☐ Demisexual
My sexual orientation is: _____

Level of Education:
☐ Some High School ☐ High School Diploma/GED ☐ Some college
☐ Associate ☐ Bachelor's ☐ Master's
☐ Doctorate ☐ Trade/Vocational Certificate

Employment Status
☐ Unemployed ☐ Underemployed ☐ Self-Employed
☐ Work Full-time ☐ Work Part-time ☐ Student
☐ Retired ☐ On Disability (SSDI, SDI) ☐ Temp State Dis.

Housing Status: ☐ Own ☐ Rent ☐ Hotel ☐ Foster Home ☐ Group Home ☐ Homeless

Who do you live with?
☐ Alone ☐ With Family ☐ With Friends ☐ With Partner
☐ Decline to State ☐ Roomates

Housing is:
☐ Stable/Permanent ☐ Unstable/Permanent
☐ Stable/Temporary ☐ Unstable/Temporary

Household Income: Number of People in household: _____
☐ Under $12,000 ☐ $12,000-14,999 ☐ $15,000-24,999 ☐ $25,000-34,999
☐ $35,000-49,999 ☐ $50,000-74,999 ☐ $75,000-99,999 ☐ $100K & Over

Citizenship: ☐ U.S. Citizen ☐ Documented Resident ☐ Undocumented Resident ☐ Decline to state

Ethnicity/Race:
☐ African ☐ African-American ☐ Asian ☐ Asian Indian
☐ Black, Non-Hispanic ☐ Cambodian ☐ Chinese ☐ Cuban
☐ Caucasian/White ☐ Central American ☐ European ☐ Filipino
☐ Guamanian/Chamorro ☐ Hawaiian ☐ Hispanic ☐ Hmong
☐ Iranian ☐ Iraqi ☐ Israeli ☐ Japanese
☐ Kenyan ☐ Korean ☐ Laotian ☐ Latino
☐ Mexican/Chican@ ☐ Mexican-American ☐ Multiracial ☐ Middle Eastern
☐ Pacific Islander ☐ Puerto Rican ☐ Persian ☐ Pakistani
☐ Russian ☐ Samoan ☐ Somali ☐ South American
☐ Southeast Asian ☐ Spanish ☐ Taiwanese ☐ Thai
☐ Tongan ☐ Ukrainian ☐ Vietnamese
☐ Alaskan Native or North American Native, Tribe: _____
My ethnicity/race: _____

Primary Language:
☐ Spanish ☐ English ☐ Arabic ☐ American Sign Language
☐ Cantonese ☐ Hmong ☐ Ukrainian ☐ Russian Additional: _____

MRN: _____ Demographics

Personal confidentiality is strictly guaranteed when completing this demographic form. Data collected will be used for informal purposes when creating new programming and securing funding or resources for Gender Health Center.

- We recognize the fact that no one person can fit into any box and everyone has the right to state their own identity which may not have been included on our list which is why we have included a write in section.
- We promote open expression of our individuality and our diversity with the bounds of courtesy, sensitivity, and respect. We confront and reject all manifestations of discrimination, including these based on race, ethnicity, gender (including gender identity and gender expression), sexual orientation, age, disability, religious or political beliefs, status, or any other differences among people which have been excuses for misunderstanding, dissension or hatred.
- We recognize and cherish the richness contributed to our lives by our intersectionality. We take pride in our various achievements, and we celebrate our differences.
- We affirm the right to freedom of expression within our community and also affirm our commitment to the highest standards of civility and decency towards all.
- We recognize the right of every individual to think and speak as dictated by personal belief, to express and idea, and to disagree with or counter another's point of view.
- We recognize that each of us has an obligation to the community of which we have chosen to be a part of. We will strive to build a true community of spirit and purpose based on mutual respect and caring.

Informed Consent for Testosterone Therapy

This form refers to the use of testosterone by persons who wish to become more masculinized as part of a gender transitioning process. Testosterone treatment will cause some permanent and many reversible changes to your body. Before you start taking testosterone, it is important that you have a good understanding of these effects as well as the risks involved in taking testosterone.

If you have any questions or concerns about the information below, we encourage you to take all the time you need to ask questions, read, research, and talk with your provider while thinking about these important aspects of your treatment.

It is also important that you understand that testosterone is not the only way that you can choose to receive treatment. Just as chromosomes and genitals do not define your gender identity; neither do hormones in your body or surgeries you choose to have. So it is important that you decide what goals you would like to achieve in your treatment and discuss these with your healthcare provider. Gender identity can only be determined by you and how *you feel inside,* not the choices you make about your medical care.

****Initial next to every paragraph****

_____I identify as having a male/masculine and/or a gender non-conforming gender identity and therefore wish to be treated with testosterone.

_____I understand that taking testosterone does not necessarily prevent future reproduction and/or parenting, but that it is not known exactly what the effects of testosterone are on fertility. I understand that pursing hormonal therapy may make it more difficult or even impossible for me to have genetic offspring in the future. I have discussed my desires and choices with my provider and feel comfortable that I have made an informed decision about my future status.

_____I understand that testosterone can cause major birth defects if I become pregnant while taking it and that my ability to become pregnant, while reduced while on treatment, will not cease. I understand if I engage in barrier free or condomless vaginal-penis sex where semen could enter my vagina there is a chance of pregnancy. If pregnancy is not a desired outcome, some sort of birth control should be used.

_____I have been informed that effects of testosterone may take several months to become noticeable, up to five or more years to plateau. Some of these changes will be <u>permanent.</u>

- Increased hair growth on my face, arms, legs, chest, and abdomen.
- Hair loss, especially at my temples and crown of my head, possibly becoming completely bald.
- Deepened voice.
- Enlargement of the clitoris.

These additional changes will <u>not be permanent</u> if I stop testosterone:

- Increased libido and changes in sexual behavior similar to those experienced at puberty.
- Increased muscle mass.
- Decreased fat in my breast, buttocks and thighs.
- Increased fat in my abdomen.

- Increased sweat and changes in body odor.
- Increased appetite, weight gain, and fluid retention.
- Prominence of veins and coaster skin.
- Acne of the face, back, and chest, especially in the first years of treatment, which if severe may cause permanent scarring.
- Stopping of menstruation.
- Vaginal dryness and itching that may occasionally cause pain with vaginal penetration.

_____I have been informed that testosterone may cause changes in my uterus (like fibroids) or ovaries (like cysts) that may make hysterectomy (removal of the uterus) and oophorectomy (removal of the ovaries) more difficult if I eventually choose to have these surgeries.

_____I understand that taking testosterone does not make me immune to, and may possibly increase, my risk to develop certain gynecological problems, including cancer. I understand that even if I have a hysterectomy and oophorectomy I must still continue periodic gynecological exams and screenings either with my provider or another provider of gynecological care who is aware that I am taking testosterone.

_____I understand that the effects of testosterone will not protect me from cervical cancer or breast cancer. It is important to continue to be alert to the healthcare needs of my body. My provider may also recommend periodic pap smears and/or mammograms.

_____I understand the effects of testosterone will not protect me from sexually transmitted diseases or from HIV.

_____I have been informed that if I take testosterone, my good cholesterol (HDL) will probably go down and my bad cholesterol (LDL) will probably go up. This may increase my risk of heart attack and/or stroke in the future. The rates of risks for people assigned female at birth who take testosterone are that to be similar to the risks found in cisgender men. I agree to be monitored for cholesterol problems before starting testosterone and periodically during therapy.

_____I understand that testosterone can increase the risk of or worsen certain diseases (i.e., Type 2 Diabetes, high blood pressure, heart disease, migraine headaches, sleep apnea, and epilepsy). If you think you have or are developing these diseases, it is important to tell your healthcare provider. They can be treated generally without having to stop taking testosterone.

_____I have been informed that testosterone increase red blood cell counts which rarely, if severe and untreated, can increase my risk of strokes, heart disease, and blood clots.

_____I have been informed that testosterone puts a stress on the liver that may lead to inflammation. I agree to be monitored for liver problems before starting testosterone and periodically during therapy.

_____I have been informed that testosterone may increase the risk of developing osteoporosis (thinning and weakening of the bones) that may become worse after the choice of having an oophorectomy or if I stop taking testosterone.

_____I understand that there are emotional changes, both good and bad, that I may experience as a result of testosterone therapy. Additionally, if I develop mood changes, increased de-

pression, anxiety, or feelings of suicidality, I agree to tell my healthcare provider so that clinic staff can help me in finding resources to explore these changes if they are a problem.

_____I understand that once injected, if I have any adverse reactions to testosterone I must wait for them to wear off.

_____I understand that everyone's body is different and that there is no way to predict what my response will be to testosterone. I understand that the right dosage for me may not be the same as for someone else.

_____I understand that testosterone treatment may make in necessary that I have more healthcare screening tests than other people assigned female at birth my age. I will have physical examinations and blood tests periodically to make sure my body is healthy while on testosterone. I understand this is required to continue receiving testosterone therapy through this clinic.

_____I understand that an open and honest relationship with my healthcare provider is essential to keeping me healthy and safe. I agree that I will share with my provider any physical problems or side effects that I may develop especially if I think they are caused by testosterone. I understand and expect that I will never be penalized for my honesty out my body.

_____I agree to take hormones as prescribed and to inform my provider of any problems or dissatisfactions I may have with the treatment. I have been informed that if I take too much testosterone, that my body may convert it back to estrogen. This may slow or stop the desired effects of testosterone.

_____I understand that testosterone is a DEA controlled substance (like narcotic pain medicines and some sedatives) and that it is illegal to share these medications with other people. I also understand that sharing needles with anyone can place me at risk for blood diseases like HIV and hepatitis.

_____I understand that I can stop taking testosterone at any time. I also understand that my provider can discontinue treatment for clinical reasons.

_____ _____

Printed Name Date

_____

Signature

_____

Printed name of parent/guardian if patient is under 18

_____

Signature of parent/guardian if patient is under 18

Informed Consent for Estrogen Therapy

This form refers to the use of estrogen by persons who wish to become more feminized as a party of a gender transitioning process. Estrogen treatment will cause some permanent and many reversible changes to your body. Before you start taking estrogen, it is important that you have a good understanding of these effects as well as the risks involved in taking these medications.

If you have any questions or concerns about the information below, we encourage you to take all the time you need to ask questions, read, research, talk with your provider while thinking about these important aspects of your treatment.

It is also important that you understand that estrogen is not the only way you can choose to be treated. Just as chromosomes and genitals do not define your gender identity; neither do the hormones in your body or surgeries you may choose to have. So it is important that you think about and identify what goals you would like to achieve in your treatment and discuss these with your healthcare provider. Gender identity can only be determined by you and how *you feel inside,* not the choices you make about your medical care.

****Initial next to every paragraph****

_____I identify as having a female/feminine and/or a gender non-conforming gender identity and therefore wish to be treated with estrogen.

_____I understand that taking estrogen does not necessarily prevent future reproduction and/ or parenting but that it is not known exactly what the effects of estrogen are on fertility. I understand that pursuing hormonal therapy may make it more difficult or even impossible for me to have genetic offspring in the future. I have discussed my desires and choices with my provider and feel comfortable that I have made an informed decision about my future reproductive status.

_____I understand that the amount and quality of my ejaculation may decrease or stop entirely. My sperm will still be present in my testicles but I will probably stop maturing, so I may become infertile. I have been informed that I may still be able to make someone pregnant and that if I am having penis-vaginal sex with someone who can become pregnant, and pregnancy is not a desired outcome, some form of birth control should be used.

_____I understand that there are medical conditions that could make taking estrogen either dangerous or damaging. I agree that if my healthcare provider is concerned that I may have one of these conditions, I will be evaluated for it before the decision is made to start or continue estrogen therapy.

_____I have been informed that the effects of estrogen may take several months to become noticeable, and may take up to five or more years to plateau. Some of these changes will be <u>permanent.</u>

- Breast growth, although there is extreme variation in size.
- Up to a 40% shrinkage in the size of my testes.

These additional changes will not be permanent if I stop estrogen.

- Decreased acne.
- Slowing of hair loss, especially at my temples and crown of my head.
- Softer skin.
- Less noticeable body hair growth, although it will may not go away.
- Less noticeable body odor and a change in the quality of the sweat from my armpits.
- Decreased fat in my abdomen.
- Increased fat in my buttocks and thighs.
- Decreased or loss of morning and spontaneous erections and inability to obtain an erection hard enough for intercourse.
- Decreased sex drive.

_____I understand that estrogen can increase the risk of blood clots resulting in significant medical problems (i.e., chronic leg vein problems, pulmonary embolism, and stroke), brain damage and/or death. This risk is increased if I smoke tobacco and am over the age of 35. I have been advised to not smoke tobacco and have been offered smoking cessation resources if I am currently a smoker.

_____I have been informed that if I take estrogen, my "good" cholesterol (HDL) may go up and my "bad" cholesterol (LDL) will probably go down. This may decrease my risk of heart attack and/or stroke in the future.

_____I have been advised that estrogen can cause increased blood pressure. If I have high blood pressure, I may be able to take estrogen once my blood pressure is controlled (through diet, lifestyle changes and/or medications). My healthcare provider will help me address this problem.

_____I have been informed that estrogen puts a stress on the liver and that may lead to inflammation or a back-up of liver products in the bile ducts. I agree to be monitored for liver problems before starting estrogen and periodically during therapy.

_____I have been informed that estrogen may increase migraine headaches. If migraines are severe or prolonged, I agree to discuss this with my health care provider.

_____I have been informed that estrogen may increase the risk of developing osteoporosis (thinning or weakening of the bones) that may become worse if I stop taking estrogen.

_____I have been informed that estrogen may increase nausea and vomiting, most commonly in the morning. If nausea and vomiting are severe or prolonged, I agree to discuss this with my healthcare provider.

_____I understand that taking estrogen does not make me immune to, and may possibly increase, my risk to develop certain medical problems including pituitary tumors and breast cancer. My provider may recommend periodic screenings and/or mammograms.

_____I understand that the effects of estrogen will not protect me from testicular cancer or prostate cancer. I understand that even if I have an orchiectomy and.or vaginoplasty, I must still

continue periodic exams and screenings either with my provider or another provider who is aware of that I am taking estrogen.

_____I understand the effects of estrogen will not protect me from sexually transmitted diseases or from HIV.

_____I understand that estrogen may cause, or contribute to depression. If I have a history of depression, I will discuss this with my healthcare provider. Additionally, if I develop mood changes, increased depression, anxiety, or feelings of suicidality, I agree to tell my healthcare provider so that clinic staff can assist me in finding resources to explore these changes if they are a problem.

_____If I choose an injectable form of estrogen, I understand that once injected, if I have any adverse reactions to estrogen I must wait for it to wear off. I also understand that sharing needles with anyone can place me at risk for blood borne diseases like HIV/AIDS and hepatitis.

_____I understand that everyone's body is different in that there is no way to predict what will be my response to hormones. I understand that the right dosage for me may not be the same as for someone else.

_____I understand that estrogen treatment may make in necessary that I have more healthcare screening tests than other people assigned male at birth my age. I will have physical examinations and blood tests periodically to make sure my body is healthy while on estrogen. I understand that this is required to continue receiving estrogen therapy through this clinic.

_____I understand that an open and honest relationship with my healthcare provider is essential to keeping me healthy and safe. I agree to tell my medical provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs or medications I might be taking.

_____I agree to take hormones as prescribed and to inform my provider of any problems I may have with the treatment. I have been informed that if I take too much estrogen, that my body may convert it into testosterone. This may slow or stop the desired effects of the hormone.

_____I understand that I can stop taking estrogen at anytime. I also understand that my provider can discontinue my treatment for clinic reasons.

_____ _____

Printed Name Date

_____

Signature

_____

Printed Name of parent/guardian if patient is under 18

_____

Signature of parent/guardian if patient is under 18