Transgender Health Services Medical Evaluation Form

Patient's current name:_____ Date of Birth:_____

Patient's name on file with insurance, if different:_____

Hormone Therapy History ***Mark only one "yes".***

Yes

- ☐ This patient has taken 12 continuous months of hormone therapy as appropriate to the patient's gender goals, **OR**
- ☐ Hormone therapy is not appropriate for this patient's gender goals, **OR**
- ☐ This patient has medical contraindications to hormone therapy, **OR**
- ☐ This patient is unable or unwilling to take hormone therapy

Please mark either "yes" or "no" for every item on the rest of the document. All items must be completed.

Yes	No	
☐	☐	This patient has gender dysphoria

Medical conditions that could interfere with expected outcomes of proposed surgery

Yes	No		Yes	No	
☐	☐	Uncontrolled diabetes	☐	☐	History of venous thromboembolism
☐	☐	Active infection	☐	☐	History of poor wound healing
☐	☐	Severe immunosuppression	☐	☐	Obesity BMI:_____
☐	☐	Unstable cardiovascular disease			
☐	☐	Other unstable medical conditions: _____			

Other Conditions

Yes	No		Yes	No	
☐	☐	Tobacco/nicotine use	☐	☐	Other significant substance use
☐	☐	Cannabis/marijuana use			

If any medical conditions present please document plans to stabilize, including a cessation plan if patient uses nicotine:

Yes	No	
☐	☐	Medical conditions are well controlled
☐	☐	This patient has been engaged in medical care in SFDPH-affiliated clinics for at least 1 year
☐	☐	It is my opinion that the proposed surgery will benefit this patient's health
☐	☐	I have spoken with the patient's mental health provider/s about the patient's need for surgery

Medical Provider Name **Signature** **Date**

_____ _____ _____