Children's Wisconsin

Pediatric and Adolescent Gender Health Clinic Patient History Form

Welcome to the Children's Gender Health Clinic and services. We look forward to helping your child and family. Please fill out this form and send it to the clinic. You **must complete and return the form before we can make a clinic appointment** for your child. The directions where to send the form are at the end of the form.

Today's Date: _____

Patient's Full Legal Name: _____ Birthdate: _____

Affirmed name and pronouns (i.e. he, she, they): _____

Would you like the affirmed name added to the medical record? ☐ Yes ☐ No

Patient's Full Home Address (include city): _____

Parent's 10-digit Phone Number: _____

Name of patient's primary health care provider: _____

Tell us what matters most to you. What are the patient goals for your clinic visit? _____

_____

How old was the patient when they first showed gender non-conformity? _____

Has the patient started showing signs of puberty (teenage body changes such as rapid height change, breast development or bigger testicles and penis)? ☐ Yes ☐ No If yes, at what age did it start? _____

Has the patient ever had a menstrual period? ☐ Yes ☐ No If yes, at what age did it start? _____

Does the patient see a mental health therapist or psychiatrist now? ☐ Yes ☐ No

Please check if you would like information about mental health providers ☐

Does the therapist or psychiatrist help with the patient's gender questions or concerns? _____

If yes, please give the therapist's contact information:

Therapist or Psychiatrist's Name: _____

Phone: ( ) _____ Email address: _____

Patient Medical History

Allergies: On the lines below, list any medications, foods, or other things like dusts, pets, or natural plants that the patient is allergic to. List what happens if the patient has those things around them or in their body.

_____

Medicines: List the medicines that this patient takes for any reason

Medicine Name	How much do they take?	How many times a day do they take it?	When did they start taking this medicine?

Immunizations/Vaccines:

☐ The patient has had all their immunizations
☐ Not sure if the patient has had all their immunizations
☐ We do not use immunizations

Birth and developmental history

Did the patient's mother take medication during her pregnancy? ☐ No ☐ Yes

List the medicines: _____

Were there any problems with the pregnancy or birth with this patient? ☐ No ☐ Yes

List the problems: _____

Was the patient ever called a preemie? ☐ No ☐ Yes

How big was the patient when they were born? Weight: _____ Length: _____

Did the patient walk and talk about the same time, or faster, or slower than other children?_____

Patient Physical Health Information Section

If the patient has ever stayed in the hospital, emergency room, or health facility to get medical care, list the information. If you need more room, write on the last page of the form.

Date	Reason for Hospitalization/ER	Name of Hospital City, State

If the patient ever had a surgery or procedure, list the information.

Date	Surgery/Procedure	Performed By	Where it was done (hospital/clinic name)

Patient Physical Health Information Section (continued)

Check the box if this patient has ever had trouble with any of the items below.
On the line next to the problem, describe it.

- ☐ Skin concerns, spots, or birthmarks _____
- ☐ Brain, nerves, headaches _____
- ☐ Vision, hearing, taste, or smell _____
- ☐ Heart or blood pressure _____
- ☐ Breathing, asthma, or wheezing _____
- ☐ Weight or height _____
- ☐ Eating, swallowing, or appetite _____
- ☐ Stomach, bowels, constipation or diarrhea _____
- ☐ Kidneys, bladder, urination or peeing _____
- ☐ Frequent infections _____
- ☐ Muscles or bones _____
- ☐ Weakness or coordination _____
- ☐ Blood or bleeding issues _____
- ☐ Sleep issues, restlessness, snoring or _____
- ☐ Activity/energy level _____

Patient Mental and Behavioral Health Information Section

Check the box if this patient has ever had a mental or behavioral health condition on the list below.
On the line next to the condition, describe it.

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Suicidal attempt or thinking _____
- ☐ Other mental health conditions _____
- ☐ Eating Disorder(s) _____
- ☐ Drug use or overuse _____
- ☐ Alcohol use or overuse _____

If the patient has ever stayed in a mental health hospital, day, residential, or care program, list the information.
If they were ever seen in an emergency room for mental health reasons, list that also.

Date	Reason for mental health hospitalization/ER/program	Name of Hospital City, State

Patient School and Work

What grade is the patient in now?_____ What school is the patient at now?_____

How are the patient's grades in school this year?

☐ Better than last year ☐ About the same as last year ☐ Worse than last year

How many days of school did the patient miss in the last 6 months? _____

Have you talked to the school about the patient's gender identity? ☐ No ☐ Yes

What help does the patient's school have for gender non-conforming children and teens?_____

_____

Has the patient ever worked? ☐ No ☐ Yes If yes, describe: _____

_____

Patient School and Work (continued)

What kinds of things does the patient like doing?_____

_____

What kinds of things does the patient do well or is good at?_____

_____

What other things should we know to help take care of this patient?_____

_____

Please write in information or check boxes to fill in rows about the patient's parents or guardians. What are the parent or guardian goals? _____

_____

_____

Parent or Guardian 1	Parent or Guardian 2	Parent or Guardian 3
Name	Name	Name
Full Address	Full Address	Full Address
Phone	Phone	Phone
Type of work	Type of work	Type of work
Relationship to patient Mom ☐ Dad ☐ Step-parent ☐ Grandparent ☐ Foster parent ☐ Other family ☐ _____	Relationship to patient Mom ☐ Dad ☐ Step-parent ☐ Grandparent ☐ Foster parent ☐ Other family ☐ _____	Relationship to patient Mom ☐ Dad ☐ Step-parent ☐ Grandparent ☐ Foster parent ☐ Other family ☐ _____
Status Married or Partnered ☐ Single ☐ Divorced ☐ Widowed ☐	Status Married or Partnered ☐ Single ☐ Divorced ☐ Widowed ☐	Status Married or Partnered ☐ Single ☐ Divorced ☐ Widowed ☐
Lives with patient Yes ☐ No ☐	Lives with patient Yes ☐ No ☐	Lives with patient Yes ☐ No ☐
Spends time with patient Yes ☐ No ☐	Spends time with patient Yes ☐ No ☐	Spends time with patient Yes ☐ No ☐
Has legal custody of patient Yes ☐ No ☐	Has legal custody of patient Yes ☐ No ☐	Has legal custody of patient Yes ☐ No ☐
Does the patient have siblings? Yes ☐ No ☐ If yes, please list names and ages of siblings.		

Family Member Health Information Section

We ask questions about family member health to know how to care for the patient.

Check the box next to the medical condition and who in the family has it.

Medical Condition		Family Member
☐	Diabetes	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Seizures or Epilepsy	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Early heart disease or stroke	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Migraines	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Kidney issues	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Cancer	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Liver issues	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Blood issues, such as easy bleeding or blood clots	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐
☐	Mental Heath (depression, anxiety, drug or alcohol, other mental health problems)	Mom ☐ Dad ☐ Sibling ☐ Grandparent ☐ Aunt or Uncle or Cousin ☐

What worries do you or the other parents or guardians have for the patient?

- ☐ Behavioral issues
- ☐ Bullying/teasing/harassment
- ☐ Cigarette smoking
- ☐ Conflict at home
- ☐ Depression
- ☐ Gender identity concerns
- ☐ Gender presentation concerns
- ☐ Social issues
- ☐ School performance/learning issues
- ☐ Substance abuse
- ☐ Suicidal thoughts or self-harm
- ☐ One or more traumatic events
- ☐ Other concerns: _____

_____

Other Information

Is the patient in foster care? ☐ No ☐ Yes _____

Do you have interest in getting additional resources for gender health-specific needs such as school support or legal concerns? ☐ No ☐ Yes _____

Would you like assistance with basic needs resources such as food, housing, clothing etc.? ☐ No ☐ Yes

_____

We offer gender-affirming Spiritual Support to all our patients; would you like to learn more about that? ☐ No ☐ Yes

_____

How did you hear about our clinic? _____

1. **Complete** the form.
2. **Send** the completed form to the clinic **by mail or fax**.
3. The **clinic will call you** to set up an appointment for your child.

This clinic must have the form **before** they can call you to set up an appointment.

To fax the form: Phone Number: Email Address:	(414) 266-3332 (414) 266-3380 Endocrine-clinic@childrenswi.org
To mail the form:	Children's Wisconsin Gender Health Clinic MS B740 PO Box 1997 Milwaukee, WI 53226

Is is important to fill in as much of the form as you can. We look forward to helping your child and family.

Thank you, Children's Gender Health Clinic

Use the space below to add any information that did not fit on the form.