QUESTIONNAIRE FOR FTM, MTF or NonBinary/Gender Neutral Procedure(s)
(This information is required by your insurance company)

Today's Date: _____ Legal Name: _____

Pronouns: _____ Preferred Name: _____

DOB: _____

1. I have successfully lived and worked within the desired gender role fulltime without returning to original gender (years, months, etc.) including one or more of the following: Part or fulltime employment, student in an academic setting, community based volunteer activity for

   _____(#) ☐ Months ☐ Years

   Other:_____

   _____

2. I (circle one) **have / have not** been receiving hormone therapy from a qualified medical professional (e.g. testosterone, estrogen, etc.) for

   _____(#) ☐ Months ☐ Years

   The name of my provider responsible for hormone therapy is: _____
   They are located at: _____
   Their contact phone number is: _____

   ☐ Check this box if you have more than one medical professional who is responsible for your hormone therapy. The name of my second provider responsible for hormone therapy is:

   _____
   They are located at: _____
   Their contact phone number is: _____

3. I have undergone therapy for my transition with a qualified licensed mental health/behavioral health professional with expertise in the field (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) for

   _____(#) ☐ Months ☐ Years

   The name of my provider responsible for my therapy is: _____
   They are located at: _____
   Their contact phone number is: _____

   ☐ Check this box if you have more than one medical professional who is responsible for your behavioral health therapy.
   The name of my second provider responsible for behavioral therapy is: _____
   They are located at: _____
   Their contact phone number is: _____

4. I have already acquired a legal-gender-appropriate name change on: _____

   ☐ I intend to in the future ☐ I do not intend to in the future ☐ N/A

5. The gender I identify with is _____

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Patient Name:_____

DOB:_____

Primary Care Doctor: _____

Referring Doctor (if different):_____

Reason for your visit today:_____

Name:_____ Date: _____

Address: _____
Street City State Zip Code

Phone: Home:_____ Cell:_____

Email:* _____

Age:_____ Date of Birth:_____/ _____/_____ Weight:_____ Height:_____

Occupation:_____ Employer: _____

Marital Status:_____ SS#:_____

Emergency Contact:_____ Relationship:_____
Phone: Home:_____ Cell:_____

Pharmacy Name/Address/Phone number:_____

Family History: Has any blood relative ever had the following?

	No	Yes		No	Yes		No	Yes		No	Yes
Breast cancer			Depression			Melanoma			High blood pressure		
Ovarian Cancer			Heart disease			Stroke			Diabetes		
Other Cancer			DVTs (Blood clots)						Kidney disease		

List blood relatives that have had breast cancer: _____

Past Medical History: Have you had any of the following?

	No	Yes		No	Yes		No	Yes
Breast cancer			Heart disease			High blood pressure		
Ovarian Cancer			Heart murmur			Kidney disease		
Skin Cancer			Mitral valve prolapse			Liver disease		
Cancer (other than skin)			Anemia			Depression		
HIV/AIDS			Bleeding Problem			Other mental illness		
Rheumatic fever			Excessive Bleeding			Neuromuscular disease		
Tuberculosis			Blood transfusion			Autoimmune disorder		
Diabetes			History of blood thinner use			Glaucoma		
Hepatitis			History of DVTs (Blood clots)			Thyroid disease		
Cold Sores/Fever Blisters			History of miscarriages			Arthritis		
Asthma			Stroke			Other:		

Have you had a **mammogram** recently? ☐No ☐Yes, If Yes, Where?_____ When?_____

What were the results of your mammogram?_____

Have you had a biopsy?

If Yes, at what facility?_____ What were the results of your biopsy?_____

Are you: **Pregnant?_____ Nursing?_____**

Injury:

Are you being seen today for a particular injury or accident? ☐No ☐Yes

If Yes, what was the date of the injury:_____/ _____/_____

If Yes, where did the injury occur (work, home, car accident)?_____

Allergies: ☐No, I have no allergies, sensitivities or medication reactions that I know of.
☐Yes (List below)

Allergy/Sensitivity/Medication Reaction	
Medications:	
Vaccinations:	
Contrast Dye:	
Latex:	
Food/Shellfish:	
Seasonal Allergies:	
Environmental Allergies:	
Insects/Venom (e.g., Bee Stings):	
Other:	

Past Surgical History:

Date	Operation/Procedure	Date	
____/____/____		____/____/____	
____/____/____		____/____/____	
____/____/____		____/____/____	
____/____/____		____/____/____	
____/____/____		____/____/____	

Medications:

Medication/Supplement Name	Dose	How you take it (by mouth, injection, etc.)	Time of Day/How Often

DO YOU TAKE ANY VITAMINS (ex. fish oil), HERBAL SUPPLEMENTS (ex. berry supplements), OFF-LABEL SUPPLEMENTS, DIETARY SUPPLEMENTS (e.g. protein powders) AND NON-STANDARD MILKS (e.g. almond milk):
***please pay attention to supplements containing Vitamin E:**

Vitamin/Supplement Name	Ingredients (ex. Vitamin E)	Time of Day/How Often

Social History:

Do you smoke? ☐Yes ☐No If Yes, How many packs per day?_____ For how many years?_____

Any nicotine products (patches, chewing tobacco, second-hand smoke)? ☐Yes ☐No Specify_____

Any Marijuana? ☐Yes ☐No Frequency:_____ Any THC products (edibles)? ☐Yes ☐No. _____

Do you drink alcohol? ☐Yes ☐No If Yes, how many drinks per day?_____ For how many years?_____

Review of Systems: Have you had any of the following?

Constitutional Symptoms	No	Yes	**Ears, Nose & Throat**	No	Yes	**Musculoskeletal**	No	Yes
Fever			Difficulty with nasal breathing			Chronic Muscle Pains		
Loss of Energy			Difficulty Hearing			Multiple Joint Pains		
Recent Weight Gain			Ringing in Ears			Swelling of Joints		
Recent Weight Loss			**Cardiovascular**			**Skin/Breast**		
Gastrointestinal			Chest Pain			Breast Pain or Lump		
Blood in Stool			Heart Attack			Skin Rash		
Constipation			Rapid Heart Beat			**Neurological**		
Diarrhea			Swollen Ankles			Numbness		
Heartburn			**Respiratory**			Seizures		
Psychiatric			Chronic Cough			Tingling		
Anxiety			Wheezing			**Endocrine**		
Depression			**Genitourinary**			Abnormal Milk Production		
Eyes			Pain on Urination			Tremor (shaking)		
Blurry Vision			Problems Urinating			**Hematologic/Lymphatic**		
Dry Eyes			**Allergic/Immunologic**			Easy Bruising/Bleeding		
Impaired peripheral vision			Frequent, Unusual Infections			Swollen Lymph Nodes		

Complete only if you are being seen for breast-related problem: ☐NA

Breast lump or discharge?☐Yes ☐No Age of first period: ☐NA ___ Number of pregnancies: ☐NA___

Number of children: ☐NA____ Number of C-sections: ☐N/A ____ Did you breast feed? ☐Yes ☐No

Bra size: ☐NA_____

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

_____ _____OR

Patient Signature Print Name Date

_____ _____

Signature of Person completing form for Patient Print Name Relationship to Patient

Physician Review: I have reviewed the above information with the patient

_____ _____

MD Signature Print Name Date

Name of Interpreter (if applicable):_____

HIPAA Acknowledgment of Receiving Notice of Privacy Practices

Chandler Plastic Surgery
777 Post Road, Suite 304
Darien, CT 06820
Phone: (203) 423-3132 • Fax: (203) 423-0124

Health Insurance Portability and Accountability Act of 1996
Effective Date: 09/01/2019
Privacy Officer: Laurel Chandler, MD
info@laurelchandlermd.com

By signing the Acknowledgement form you are acknowledging that you received, or have been given the opportunity to receive, and have read and understand our Notice of Privacy Practices.

Signature _____ Date _____

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Acknowledgment of Receiving General Agreement and Financial Policy

By signing the Acknowledgement form you are acknowledging that you received, or have been given the opportunity to receive, and have read and understand and agree to the terms of the General Agreement and Financial Policy.

Signature _____ Date _____

ACKNOWLEDGEMENT OF READING FTM/N TOP SURGERY FREQUENTLY ASKED QUESTIONS

I hereby affirm that I have read the document, "FTM/N TOP SURGERY FREQUENTLY ASKED QUESTIONS" in its entirety and I understand the surgical risks involved in surgery as described above. I understand my compliance is an essential component of my postoperative care. I understand that not having the operation is an option.

_____

Patient or Person Authorized to Sign for Patient Printed Name and Relationship

Date _____

AUTHORIZATION FOR RELEASE
OF PATIENT PHOTOGRAPH

Name: _____

Medical Record #: _____

Date: _____

I consent to the taking of photographs by Dr. Laurel Chandler or her designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Laurel Karian Chandler. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. I further consent to the use of my images and/or recordings for the purposes of education, such as training medical students or in the context of continuing education.

I (check one) ☐DO ☐DO NOT authorize Dr. Laurel Chandler to use images and/or recordings regarding my case as a reference for current and prospective patients who are interested in having or may be having a similar procedure. The purpose of this disclosure is to assist current and future patients to evaluate the potential outcomes of such a procedure(s). The images and/or recordings may be used either in print form or posted on Laurel Chandler's website. I understand that only the images and/or recordings will be printed or posted, and will not be accompanied by any other personal information, such as my name or date of birth. This authorization will remain in effect until such images and/or recordings are removed from the Laurel Chandler's website and photo book or until I revoke my authorization in writing.

I (check one) ☐DO ☐DO NOT authorize Dr. Laurel Chandler to use video recordings of my anatomy for the purpose of contributing to educational online videos including videos posted on YouTube or other online video platforms for the purpose of helping other patients feel more comfortable and informed about the patient experience and the preoperative and postoperative process, and to provide a reference for current and prospective patients. No identifying information would be provided, such as my last name or date of birth. This authorization will remain in effect until such images and/or videos are removed or until I revoke my authorization in writing.

Patient Rights

I understand that I may refuse or revoke this authorization, in whole or in part, at any time by contacting Dr. Laurel Chandler in writing. Treatment will not be conditioned upon authorization of any or all of the above described disclosures. Whether or not I agree to allow Dr. Laurel Chandler to use and/or disclose images and/or recordings in the manners described, I will receive the same medically appropriate treatment that is afforded to all patients. If I do not revoke this authorization, it will expire ten years from the date written below. I also have the right to inspect and copy the information that you have authorized to be disclosed. When protected health information is disclosed, there is the potential that the recipient of that disclosure will re-disclose the protected health information. Such re-disclosures are not governed by HIPAA and any rights you may have under HIPAA will not apply to re-disclosures.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

_____ _____
Witness Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature Date