Phalloplasty Surgery Screening Questionnaire

NAME		AGE		SEX		WEIGHT		HEIGHT	

PART I: PRE-EXISTING PHYSICAL CONDITIONS

For each condition, please check Yes, No, or Unsure, and provide dates and a brief explanation. Please respond to all items.

DO YOU HAVE, OR HAVE YOU EVER HAD:	YES	NO	UNSURE	DATES	EXPLANATION
Anemia *(a low number of red blood cells in the blood)*					
Aneurysm *(a weakening or tearing of an artery or vein)*					
Angina *(chest pain or pressure)*					
Artificial prosthetic or orthopedic prosthesis implant					
Blood or bleeding disorder or tendency, especially in the stomach or esophagus (the tube that runs from the throat to the stomach), intestines, urinary tract, bladder, or lungs					
Cancer					
Chronic diarrhea					
Diabetes					
Heart attack					
Heart or cardiac disease					
Heart or mitral valve					
High blood pressure					
Hypertension					
Keloids					
Kidney or liver disease, including hepatitis					
Lung disease					

Signature: _____ **Date:** ___/___/___

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DO YOU HAVE, OR HAVE YOU EVER HAD:	YES	NO	UNSURE	DATES	EXPLANATION
Prolapse					
Seizure disorder					
Sleep apnea					
Stroke					
Thyroid disease					
Ulcer reflux					
Other					

PART II: SURGICAL HISTORY

Please list all operations that you have had and the date(s) the surgeries took place.

DATE	TYPE OF SURGERY

Signature: _____ **Date:** ___/___/___

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PART III: FAMILY HISTORY

Please list any family history of cardiovascular disease, hypertension, heart attack, stroke, cancer, diabetes, depression, keloids, or body image disorder. Please indicate the relationship of each family member listed (mother, father, aunt, uncle, etc.)

FAMILY MEMBER	RELATIONSHIP	MEDICAL CONDITION

Signature: _____ **Date:** ___/___/___

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PART IV: CURRENT MEDICATIONS

QUESTION	YES	NO
Are you taking any blood thinning medications, such as Coumadin or Warfarin?		

Please list ALL medications and herbal, vitamin, and mineral supplements you are taking. This includes prescription and non-prescription items including, but not limited to, Aspirin™, Ibuprofen™, Advil™, Ecotrin™, and NSAIDs. Please include dosage and frequency as well as anything you have taken over the past week. Attach extra pages, if necessary.

MEDICATIONS & SUPPLEMENTS	DOSAGE	FREQUENCY

Signature: _____ **Date:** ___/___/___

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PART V: ALLERGIES AND INTOLERANCES

QUESTION	YES	NO
Are you allergic to latex?		

Please list any medications, including antibiotics, to which you are allergic or for which you have an intolerance. Please list the type of reaction for each medication. Attach extra pages, if necessary.

MEDICATION TO WHICH YOU ARE ALLERGIC	YOUR REACTION TO THIS MEDICATION

Signature: _____ **Date:** ___/___/___