QUESTIONNAIRE

Before to have an appointment thank you to fill the questionnaire below:

GENERAL INFORMATIONS

Name: (as in passport)

Surname: (Family Name): (as in passport)

Birth gender:

Gender:

Your pronouns:

Preferred language:

Nationality:

Passport: or Travel Document Number

Birth:

Current Address:

Phone Number: (with country code)

Email Address:

Your Skype ID:

Weight: (specify kilograms or pounds)

Height: (specify cm or inches)

Person to contact in case of emergency

Name:

Phone Number:

Email Address:

Address:

MEDICAL HISTORY

Did you have surgical procedure since your day of birth? Yes ☐ No ☐

If yes, explain:

Did you have anaesthetic problem or one of your family member did have anaesthetic problem? Yes ☐ No ☐

Did you have or do you have Lung Problems? (such asthma or other other breathing difficulties) Yes ☐ No ☐

If yes, explain:

Heart Problems? Yes ☐ No ☐

If yes, explain:

Diabetes or Blood Sugar Problems? Yes ☐ No ☐

If yes, explain:

Thyroid Problems? Yes ☐ No ☐

If yes, explain:

Blood Pressure Problems? Yes ☐ No ☐

If yes, explain:

Have you been diagnosed with deep vein trombosis? Yes ☐ No ☐

If yes, explain:

Have you been diagnosed with malignant hypothermia? Yes ☐ No ☐

If yes, explain:

Previous or Current History of Cancer? Yes ☐ No ☐

If yes, explain:

Kidney Problems? Yes ☐ No ☐

If yes, explain:

Liver Problems? Yes ☐ No ☐

If yes, explain:

Do you have any blood disorders, such as bleeding or clotting problems? Yes ☐ No ☐

Do you have Hepatitis B or Hepatitis C or are you HIV+? Yes ☐ No ☐

Have you ever taken an MAO inhibitor such as Nardil, Marplan or Parnate? Yes ☐ No ☐

If yes, which and when was last dose:

Have you ever taken an anticoagulant such as Coumadin, Heparin or a daily aspirin or others anticoagulant? Yes ☐ No ☐

If yes, which and when was last dose:

Have you had any medical care within the past 12 months? Yes ☐ No ☐

If yes, which and when was last dose:

Have you had weight loss surgery? Yes ☐ No ☐

If yes, when, which procedure, how much weight lost:

Have you previously had surgery of any type? Yes ☐ No ☐

If yes, when, list procedure(s) and date performed:

Do you have any implants or any metal objects in your body? Yes ☐ No ☐

If yes, explain:

Do you form keloids or have any difficulty with healing or scarring? Yes ☐ No ☐

Are you allergic to any food, drug or anything else? Yes ☐ No ☐

If yes, explain:

Are you allergic to any food, drug or anything else? Yes ☐ No ☐

How much do you smoke now?:

When was your last cigarette or tobacco product?

Do you drink alcohol? Yes ☐ No ☐

If yes, how much and how often:

(ml/day, ounces/week)

Do you need assistance in walking? Yes ☐ No ☐

Have you had or do you have any medical conditions not mentioned above? Yes ☐ No ☐

If yes, explain:

Any additional information your surgeon should know but we didn't ask about? Yes ☐ No ☐

If yes, explain:

Have you had any traumatic experience during the past year such as a divorce, loss of a loved one or extreme stress? Yes ☐ No ☐

Have you ever suffered any nervous breakdowns or depression? Yes ☐ No ☐

Do you have any diagnosed neurologic problems? Yes ☐ No ☐

Do you have any problem with chronic physical pain or fibromyalgia? Yes ☐ No ☐

---------- CURRENT MEDICAL SITUATION ----------

What medications are you currently taking?

list all and dosages

What vitamins or other nutritional supplements are you currently taking?

list all and dosages

Are you taking any form of anti-depressants? Yes ☐ No ☐

Do you have high blood pressure? Yes ☐ No ☐

If yes, please list the medication and inform about details

What was your last blood pressure reading?

---------- ABOUT THE EXPECTED SURGERY ----------

What Specific Results Do You Expect?

Questions for the Surgeon:

Have you made yourself aware of the risks involved in the surgery you want?

Have you made yourself aware of all the possible complications that can occur from the surgery you want?

Specific questioner for:
Erection for phalloplasty/ ZSI 475 FTM or ZSI 100 FTM

Date of phalloplasty procedure:

Letter of psychiatric physician to provide