SAMPLE RECOMMENDED QUESTIONS FOR LGBT-SENSITIVE INTAKE FORMS

These are sample questions to include as part of your intake form or ideally when taking a patient's oral history as part of a comprehensive intake; please do NOT use this list as an intake form.

Legal name

Name I prefer to be called (if different)

Preferred pronoun?

- ❑ She
- ❑ He

Gender: Check as many as are appropriate (An alternative is to leave a blank line next to Gender, to be completed by the patient as desired)

- ❑ Female
- ❑ Male
- ❑ Transgender
  - ❑ Female to Male
  - ❑ Male to Female
  - ❑ Other
- ❑ Other (leave space for patient to fill in)

Are your current sexual partners men, women, or both?

In the past, have your sexual partners been men, women, or both?

Current relationship status (An alternative is to leave a blank line next to current relationship status)

- ❑ Single
- ❑ Married
- ❑ Domestic Partnership/Civil Union
- ❑ Partnered
- ❑ Involved with multiple partners
- ❑ Separated from spouse/partner
- ❑ Divorced/permanently separated from spouse/partner
- ❑ Other (leave space for patient to fill in)

Living situation

- ❑ Live alone
- ❑ Live with spouse or partner
- ❑ Live with roommate(s)
- ❑ Live with parents or other family members
- ❑ Other (leave space for patient to fill in)

Children in home

- ❑ No children in home
- ❑ My own children live with me/us
- ❑ My spouse or partner's children live with me/us
- ❑ Shared custody with ex-spouse or partner

Sexual Orientation Identity

- ❑ Bisexual
- ❑ Gay
- ❑ Heterosexual/Straight
- ❑ Lesbian
- ❑ Queer
- ❑ Other (state "please feel free to explain" and leave space for patient to fill in)
- ❑ Not Sure
- ❑ Don't Know

What safer sex methods do you use, if any?

Do you need any information about safer-sex techniques? If yes, with:

- ❑ Men
- ❑ Women
- ❑ Both

Are you currently experiencing any sexual problems?

Do you want to start a family?

Are there any questions you have or information you would like with respect to starting a family?

Do you have any concerns related to your gender identity/ expression or your sex of assignment?

Do you currently use or have you used hormones (e.g., testosterone, estrogen, etc.)?

Do you need any information about hormone therapy?

Have you been tested for HIV?

- ❑ Yes
  most recent test (space for date)
- ❑ No

Are you HIV-positive?

- ❑ Yes
  when did you test positive? (space for date)
- ❑ No
- ❑ Unknown

I have been diagnosed with and/or treated for:

- ❑ Bacterial Vaginosis
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Herpes
- ❑ HPV/human papilloma virus
  (causes genital warts & abnormal pap smear)
- ❑ Syphilis
- ❑ None

Have you ever been diagnosed with or treated for Hepatitis A, B, and/or C?

- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

Have you ever been told that you have chronic Hepatitis B or C, or are a "Hepatitis B or C carrier?"

- ❑ If yes, which and when?

Have you ever been vaccinated against Hepatitis A or B?

- ❑ Vaccinated against Hepatitis A
- ❑ Vaccinated against Hepatitis B

Below is a list of risk factors for Hepatitis A, B, or C. Check any that apply to you.

- ❑ Sexual activity that draws blood or fluid
- ❑ Multiple sex partners
- ❑ Oral-fecal contact
- ❑ Sexual activity during menstrual period
- ❑ Travel extensively
- ❑ Tattooing, piercing
- ❑ Use intravenous or snorted drugs
- ❑ Ever been diagnosed with or treated for an STD
- ❑ Close contact with someone who has
  chronic Hepatitis B or C
- ❑ None apply
- ❑ Not sure if any apply