Top Surgery Evaluation Form

-Name:

-Who referred you to Surgical Services PC?

-What are your preferred pronouns?

-At what age have you noted gender dysphoria?

-When did you come out to your family and friends?

-Who is your support system?

-Are you on steroid therapy? Yes / No
If yes, how long?

-Have you been binding? Yes / No
If yes, how long?

-Do you have depression or anxiety? Depression / Anxiety / Both
-Are these conditions well managed? Yes / No
-Who is your mental health provider?

-Do you have a letter of support for top surgery from your provider? Yes / No

-Do you have a personal history of:

- ☐ Bleeding disorder
- ☐ Blood clots

-Who will take care of you during recovery from surgery?

____

-What is your goal?

a. Do you want to preserve your nipples? Yes / No
b. What is more important to you: contour or minimizing scars?
c. Do you desire masculine chest or more neutral? Masculine / Neutral

Physical exam:

- ☐ Stria
____
- ☐ Skin quality
____
- ☐ Skin or nipple retraction
____
- ☐ Palpable masses
____
- ☐ Size of NAC
____
- ☐ Pec development
____
- ☐ Lymphadenopathy
____
- ☐ Scars
____
- ☐ Piercing
____