



## Preventive Care Checklist for Testosterone-based GAHT Patients

For annual health assessments of transmasculine patients, applying to patients who were assigned female at birth and have a gender identity that is male or on the masculine spectrum, who may or may not have accessed hormonal and/or surgical treatments for gender dysphoria/ gender incongruence.

Prepared by: Dr. A. Bourns · Adapted from the Preventive Care Checklist Form © 2016 - Terminology updated by 2SQTP-NB/P2SQT-NB 2022.

(see Ridley, J, Ischayek, A., Dubey, V., Iglar, K., *Adult health Checkup: Update on the Preventive Care Checklist Form* © Canadian Family Physician, 2016 Apr; 62:307-313)

### IDENTIFYING DATA:

Name: \_\_\_\_\_

Tel: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Examination: \_\_\_\_\_

### MEDICAL TRANSITION HISTORY:

#### Testosterone:

- Yes, If Yes, Start Date: \_\_\_\_\_  
 No

#### Chest Reconstruction:

- Yes  
 No

#### TAH:

- Yes  
 No

#### BSO:

- Yes  
 No

#### Clitoral Release:

- Yes  
 No

#### Meta:

- Yes  
 No

#### Phallo:

- Yes  
 No



**LIFESTYLE/HABITS/PSYCHOSOCIAL:**

**Diet:** \_\_\_\_\_

Fat/Cholesterol: \_\_\_\_\_

Fiber: \_\_\_\_\_

Calcium: \_\_\_\_\_

Sodium: \_\_\_\_\_

Exercise: \_\_\_\_\_

**Work/Education:** \_\_\_\_\_

**Economic Status:** \_\_\_\_\_

**Social supports:** \_\_\_\_\_

Family (including chosen family): \_\_\_\_\_

Relationships: \_\_\_\_\_

Sexual History: \_\_\_\_\_

**Family Planning/Contraception:** \_\_\_\_\_

**Name change/identification:** \_\_\_\_\_

Sleep: \_\_\_\_\_

Smoking: \_\_\_\_\_

**Alcohol:** \_\_\_\_\_

Safe Guidelines  $\leq 10/\text{week}$ ,  $\leq 2/\text{day}$

**Drugs:** \_\_\_\_\_

**CURRENT CONCERNS**



## MENTAL HEALTH

### Screen for:

#### Depression

- Positive
- Negative

#### Suicidal Ideation Self-harm

- Positive
- Negative

#### Anxiety

- Positive
- Negative

#### Persistent Gender Dysphoria

- Positive
- Negative

#### Experiences/Impacts of transphobia

- Positive
- Negative

## EDUCATION/COUNSELLING

### Behavioural

- adverse nutritional habits
- dietary advice on fat/cholesterol
- adequate calcium intake (1200 mg daily diet + supp)
- adequate vitamin D (1000 IU daily)
- hormone adherence
- regular, moderate physical activity
- avoid sun exposure, use protective clothing
- safe sex practices/STI counselling/PrEP indications/ assess need for birth control.

- assess need for folic acid (0.4-0.8 mg)

### Overweight (BMI 25-29) or Obese (BMI 30-39)

- Overweight (BMI 25-29)
- Obese (BMI 30-39)
  - structured behavioural interventions for weight loss
  - screen for mental health contributors
  - multidisciplinary approach

### Underweight

- Underweight (BMI < 18)
  - screen for eating disorders

### Smoking

- smoking cessation
- nicotine replacement therapy/other medications
- dietary advice on fruits and green leafy vegetables
- referral to validated smoking cessation program

### Alcohol & other substances

- case finding for problematic substance use
- counselling for problematic substance use
- referral for substance abuse treatment
- provide naloxone kit if indicated



**Elderly**

- cognitive assessment (if concerns)
- fall assessment (if history of falls)  
advanced care planning

**Oral hygiene**

- brushing/flossing teeth
- fluoride (toothpaste/supplement)
- tooth scaling and prophylaxis
- smoking cessation

**Personal safety**

- hearing protection
- noise control programs
- seat belts
- injection safety
- bathroom safety

**Parents with children**

- poison control prevention
- smoke detectors
- non-flammable sleepwear
- hot water thermostat settings (<54°C)

**UPDATE CUMULATIVE PATIENT PROFILE**

- Family History
- Medications

- Hospitalizations/Surgeries
- Allergies

**PHYSICAL EXAMINATION:**  
Physical examination, as required, taking into consideration pre-existing conditions and presenting complaints

BP \_\_\_\_\_  
HT \_\_\_\_\_  
WT \_\_\_\_\_  
BMI \_\_\_\_\_

Or See EMR Vitals

**May include:**  
Chest \_\_\_\_\_  
Pelvic/Pap \_\_\_\_\_  
Ano-rectum \_\_\_\_\_  
Derm \_\_\_\_\_

**FUNCTIONAL INQUIRY**

HEENT: \_\_\_\_\_  
CVS: \_\_\_\_\_  
Resp: \_\_\_\_\_  
Chest: \_\_\_\_\_  
GI: \_\_\_\_\_  
GU/PV bleeding: \_\_\_\_\_  
Sexual Function: \_\_\_\_\_  
MSK: \_\_\_\_\_  
Neuro: \_\_\_\_\_  
Derm: \_\_\_\_\_  
Constitutional Sx: \_\_\_\_\_



Labs/Investigations	≤64 YEARS	≥65 YEARS
	Mammogram (q2 yrs age 50-74 if no chest reconstruction)	Mammogram (q2 yrs age 50-74 if no chest reconstruction)
	Cervical cytology (q3 yrs if ever sexually active and 21-69 yrs)	Cervical cytology (q3 yrs if ever sexually active and up to 69 yrs)
	Fecal immunochemical test (FIT) (age 50-64 q2 yrs) OR Sigmoidoscopy OR Colonoscopy	Fecal immunochemical test (FIT) (up to 74 yrs q2 yrs) OR Sigmoidoscopy OR Colonoscopy
	GC/CT/Syphilis/HIV/HBV/HC V screen (high risk)	GC/CT/Syphilis/HIV/HBV/HC V screen (high risk)
	Bone Mineral Density if at risk	Bone Mineral Density
		Audioscope (or inquire/whispered voice test)
	<b>Consider Anal Pap if history of receptive anal sex, q2-3 yrs or yearly if HIV+ (age range not defined)</b>	

#### ANNUAL BLOOD WORK (ALL AGES, ASSUMING 1 YEAR ON HORMONE THERAPY)

Lab Test	Indication
CBC*	yearly
ALT+/-AST	per provider discretion
Total testosterone	yearly
Hba1c or FPG	at 12 mos, then per routine guidelines
LH	yearly if agonadal
Lipid Profile	at 12 mos, then per routine guidelines
Total testosterone	on antiandrogen
*use male reference range for ULN Hb/Hct	



IMMUNIZATIONS	≤64 YEARS	≥65 YEARS
	Tetanus vaccine q10 yrs	Tetanus vaccine q10 yrs
	Influenza vaccine q1 yr	Influenza vaccine q1 yr
	Acellular pertussis vaccine	Pneumococcal vaccine
	Varicella vaccine (2 doses)	Acellular pertussis vaccine
	Human papillomavirus vaccine (consider up to age 45 yrs, publicly covered ≤26 yrs if sexually active with MSM)	Varicella vaccine (2 doses)
	Measles/mumps/rubella vaccine	Herpes zoster vaccine (publicly covered 65-70yrs)
	Meningococcal vaccine	
	Herpes zoster vaccine (consider ≥60 yrs)	
	Hepatitis A/Hepatitis B	

**ASSESSMENT AND PLANS**



## EXPLANATIONS FOR TRANS- SPECIFIC RECOMMENDATIONS

**Note:** This form has been adapted with permission from Dr. V. Dubey from the CFPC-endorsed Preventive Care Checklist Form©. The use of these trans-specific forms assumes familiarity with the original forms and their explanations. The original form contains graded evidence- based recommendations, which may or may not be applicable to 2STIGD patients. Unbolded recommendations should be followed as per the original forms. The specific recommendations herein represent an effort to incorporate expert opinion and limited trans-specific evidence with standard National and Provincial primary care practices in a practical format that can be accessed at the point-of-care.

### MEDICAL TRANSITION HISTORY

Establishment of a patient's status regarding gender-related treatments and timing of these treatments at the outset of a preventive care assessment allows for patient-centered tailoring of counselling, education, physical examination, and screening recommendations.

### LIFESTYLE/HABITS/PSYCHOSOCIAL

An effort should be made to assess the impact of transition/trans identity, experiences of transphobia and impact on employment, housing, family, relationships, and economic well-being.

**Social Supports** – specific attention should be given to assessing the extent of

a patient's social support, creating an opportunity to suggest additional resources if needed.

**Sexual History** – delineating the types of sex that a patient is having and with whom will direct the indicated type and frequency of STI screening.

**Family Planning/Contraception** – transmasculine patients considering hormonal treatment and/or gonadectomy should be counselled regarding the option for fertility preservation. See also potential for pregnancy/need for birth control below.

Name change/identification – assess patient need/desire to change name and/or sex marker on identification and offer support for this process.

Alcohol – estrogen affects the metabolism of alcohol by the liver and has been associated with elevation in liver enzymes, thus we suggest using the same safe-drinking guidelines for transfeminine individuals as for cis women (i.e. max 10 drinks a week with no more than 2 drinks a day most days, see Canada's Low-risk Alcohol Drinking Guidelines).

Sleep – testosterone therapy may worsen or unmask obstructive sleep apnea consider inquiring re: symptoms of sleep apnea; in those with sleep apnea, CPAP requirements may change with masculinizing hormone therapy and should be monitored.



## FUNCTIONAL INQUIRY

**An effort should be made to use language consistent with a patient's gender identity; if unsure - consider asking the patient how they refer to their gendered body parts.**

Mental Health – inquire re: experiences and impacts of transphobia; screen for mood disturbances including irritability, anger, and depression, as well as anxiety (particularly social anxiety) and self-harm; suicidal ideation and attempts are particularly high in the trans population and should be specifically inquired about; inquire regarding symptoms of hypomania, mania, or psychotic symptoms in patients on testosterone who have underlying psychiatric disorders that include such symptoms; inquire re: current level of gender dysphoria and body image, (re-)assess patient interest in transition related surgeries if not undergone

Chest – inquire regarding skin changes, lumps/ bumps and nipple discharge regardless of surgical status, if patient has undergone chest reconstruction, consider asking about scarring and patient satisfaction with surgical outcome (in some cases, revisions can be considered to optimize cosmetic appearance); if patient has not

undergone chest reconstruction consider asking about binding (the practice of compressing chest tissue to create a flatter appearance) and any associated MSK, dermatologic, or respiratory symptoms; encourage the use of a product designed specifically for the purpose of chest binding (several commercial brands are available, for a comparison see '[Chest Binding 101](#)') and discourage the use of other products such as tensors or duct tape; binding frequency (#days/week), and to a lesser extent binding intensity (#hours/day) have been found to be positively correlated with negative effects, suggesting that 'days off' and/or shortened duration of binding may minimize complications); most manufactures recommend maximum use of 8 hours per day. Some private insurance companies will cover the cost of a commercial binder as a medical device with a prescription.

GU/PV Bleeding – inquire about symptoms of vaginal atrophy (if on testosterone), vaginal bleeding, discharge, and pelvic pain. Problematic symptoms due to vaginal atrophy often respond to topical estrogen; pelvic pain may be associated with cyclic testosterone dosing – changing the





frequency/route of testosterone and/or the use of NSAIDs can be helpful.

NB: any unexplained vaginal bleeding once full menstrual cessation has been achieved on testosterone warrants a full work-up for endometrial hyperplasia/malignancy.

Sexual Function – Inquire regarding libido/ hypersexual behaviour, dyspareunia (as indicated by surgical status and sexual activity), and post-orgasmic uterine cramping.

Derm – inquire re: acne and androgenic alopecia, both of which may be managed as in cis patients.

## **EDUCATION/COUNSELLING**

Adequate Calcium Intake – all patients on testosterone-based GAHT should ensure a minimum intake of 1200 mg of Calcium daily (total: diet + supplements).

Adequate Vitamin D – all patients on testosterone-based GAHT should take 1000 IU of vitamin D daily.

Hormone Adherence – missed doses of testosterone may impact bone health if post-oophorectomy, while extra doses may lead to a host of problems associated

with suprathreshold testosterone levels.

Regular, moderate physical activity – weight-bearing exercise helps in osteoporosis prevention; to avoid tendon rupture in transmasculine individuals on testosterone weight loads used in strength training should be increased gradually with an emphasis on repetitions and stretching.

Safe sex practices/STI counselling – transmasculine patients may be at high risk of STIs depending on behavioural factors; inquire re: sexual practices and risks including sex work; safer sex counselling, frequent screening (i.e. every 3 months) and an assessment of indications for HIV PrEP are indicated for those at high risk. For patient-centred handout materials, see [PRIMED2: A Sex Guide for Trans Men into Men](#).

Potential for pregnancy/need for birth control – transmasculine patients on testosterone (who have not undergone hysterectomy) may become pregnant even if menstrual suppression has been achieved and should be counselled in this regard; given that testosterone is a teratogen, reliable birth control should be instituted where pregnancy is a risk based on sexual activity; signs and symptoms of pregnancy can be reviewed,



as well as options and resources should unplanned pregnancy occur.

Need for folic acid – transmasculine patients not on testosterone and in whom pregnancy is possible based on sexual activity, as well as for those who are hoping to achieve pregnancy, folic acid recommendations are the same as for cis women.

Overweight/Obese – screen for mental health contributors – persistent gender dysphoria may be associated with a desire to maintain a larger body habitus in order to hide indicators of sex assigned at birth, which may have negative health impacts; strategizing around other ways to address persistent gender dysphoria may be helpful; barriers to physical activity can also include an avoidance of gyms/locker rooms which the provider may help strategize around; screening for eating disorders is also warranted (see below)

Underweight - screen for disordered eating – persistent gender dysphoria/incongruence may be associated with a desire to maintain a thinner body habitus in order to hide indicators of natal sex, which may have negative health impacts; strategizing around other ways to address persistent

gender dysphoria/incongruence may be helpful.

Smoking – tobacco use can worsen polycythemia (Hb/Hct above male range) which can be associated with testosterone administration, and increases the risk of CVD and thromboembolic events.

Alcohol and other substances – substance use is more prevalent in members of the 2SLGBTQIA+ community; inquire re: problematic use of substances including hormones without a prescription; if referral to a substance abuse program is indicated, consider an 2SLGBTQIA+-specific or 2SLGBTQIA+-positive program. Offer safer smoking and injection kits when indicated for harm reduction. A naloxone kit and instructions on use should be offered to all patients who are at risk of opioid overdose, as well as friends and family of those at risk.

Advanced care planning – A discussion regarding advanced care planning is recommended at least once for patients  $\geq 65$ . 2STIGD may have particular needs in ensuring that their gender identity and expression are respected and a respectful decision-maker is chosen.



Injection safety – for patients who self-inject testosterone: confirm dose, review aseptic injection technique, inquire re: rotating injection sites, injection site reactions, and pre-injection anxiety; consider conversation re: SC vs. IM injection vs. transdermal route options, ensure safe sharps disposal.

Bathroom safety - finding a bathroom that feels comfortable and safe can frequently be a source of stress for trans individuals. Resources such as [Refuge Restrooms](#) can assist trans people in locating gender neutral bathrooms. For those who may be experiencing urinary frequency due to spironolactone, timing of administration can be adjusted if safe bathroom access is a concern.

## PHYSICAL EXAMINATION

Chest – testosterone therapy is not thought to increase the risk of breast cancer; for individuals who have not undergone chest reconstruction, clinical chest (i.e. breast) exam is of questionable utility but can be considered according to a provider’s common practice with cis women; individuals who have undergone chest reconstruction are at low risk and chest and axillary lymph node exam are of questionable utility but may be considered to assess for abnormalities in the remaining breast tissue; if an

abnormality is noted in this case, ultrasound +/- MRI is indicated as mammography is technically difficult or may be impossible.

Pelvic/Pap – follow cervical cancer screening guidelines as for cis women if the cervix is present; there is no evidence to support the performance of a bimanual exam but if uterus and/or ovaries are present this can be considered according to the clinician’s routine practice with cis women, and may be helpful in determining the appropriate width/ length of speculum to use; several strategies may be employed to minimize the discomfort/trauma associated with speculum examination for some individuals. Barring contraindications, topical 2% lidocaine jelly may be applied vaginally 5-10 minutes prior to the procedure in those who find speculum examination painful due to atrophic changes. The pre-procedural administration of low-dose lorazepam or the use of vaginal estrogens for 1 week prior to the exam may also be helpful.

Ano-rectum – for those who engage in receptive anal sex, visual examination of the perianal region for any evidence of anal warts or other anorectal problems such as hemorrhoids should be considered; particularly those who are HIV+. Additionally, consider DRE for



detection of internal lesions. HIV+ patients with physical findings consistent with warts or other HPV-related changes should also be referred for HRA

Derm – examine for acne and androgenic alopecia

## LABS/INVESTIGATIONS

Mammography – for transmasculine patients who have not undergone chest reconstruction, follow guidelines as for cis women; mammography is not required following chest reconstruction; for all transmasculine patients, if a strong family history of breast cancer is present, follow the same guidelines as for cis women regarding indications for referral to a high risk screening program/genetic assessment.

GC/CT/Syphilis/HIV/HBV/HCV screen – consider STI detection from the following sites as indicated: throat, urethra, vagina, ano-rectum, and serum.

NB: Self-collected frontal (vaginal) swabs may be more sensitive for diagnosing GC and CT than provider-collected swabs and first-catch urine and may help minimize discomfort for trans patients

Cervical cytology – see Pelvic/Pap above, if patient is on testosterone, ensure to note this on the cytology requisition in

order to minimize histological misinterpretation; inadequate samples are more common in patients on testosterone and repeat may be required - the use of both brush and broom may increase yield in patients with atrophic changes.

Yearly bloodwork – yearly investigations listed are for those currently on testosterone; bloodwork should be tailored to the patient’s hormone regimen, risk factors and pre-existing conditions; screening for DMII and dyslipidemia should be performed at baseline and 1 year following hormone therapy initiation; and otherwise according to routine guidelines for cis patients. Framingham calculation will be less reliable with exogenous hormone use - depending on the age of hormone initiation and duration of hormone exposure providers may choose to use the risk calculator for sex assigned at birth, affirmed gender, or an average of both.

**Note: For patients on testosterone male reference ranges should be used for Hb/Hct, however the lower limit of the female range can be used if menstruating.**

BMD – there is no evidence to suggest that testosterone therapy negatively



impacts BMD; in accordance with national recommendations, perform bone mineral density testing in all patients over age 65.

BMD should be considered earlier in those at high risk, such as those who, for a significant period of time (i.e. >2 yrs):

- have been on low-dose or no hormones and are agonadal
- have been on a GnRH analogue without exogenous estrogen

BMD testing may additionally be considered in agonadal patients with elevated LH. Note: frequency of BMD screening will depend on the results of the initial scan

Anal Pap Screening - for those who have a history of receptive anal sex, consider anal pap every 2-3 years or yearly in those who are HIV+ (if local HRA for the follow up of abnormal results is available).

## IMMUNIZATIONS

Hepatitis A/Hepatitis B – transmasculine patients may be at higher risk of Hep A/B depending on behavioural risks, trans MSM qualify for publicly funded vaccination.

HPV – consider HPV vaccination in patients up to age 45; publicly covered ≤26 yrs if sexually active with MSM.

CFPC – College of Family Physicians of Canada, STI – sexually transmitted infection,

RHO – Rainbow Health Ontario,

CPAP – continuous positive airway pressure, MSK – musculoskeletal,

GU – genitourinary,

PV – per vagina,

NSAIDs – non-steroidal anti-inflammatories,

IU – international units,

Hb - Hemoglobin,

Hct - Hematocrit,

2SLGBTQIA+ – lesbian, gay, bisexual,

trans, queer, and two-spirit, BMI – body mass index,

CVD – cardiovascular disease,

CAMH – Centre for Addiction and Mental Health ,

MRI – magnetic resonance imaging,

DRE - digital rectal exam, HRA - high resolution anoscopy,

HIV – human immunodeficiency virus,

GC – gonococcus,

CT – chlamydia trachomatis,

HBV – Hepatitis B virus, HCV – Hepatitis C virus,

DMII - diabetes mellitus type II,

Hb - hemoglobin, Hct - hematocrit,

BMD – bone mineral density,

LH – luteinizing hormone,

MSM – men who have sex with men,

HPV – human papillomavirus,

MSM - men who have sex with men

