MoZaic Care

MEDICAL INTAKE FORM

Date: ……

Reason for Consultation: ……

Name I wish to be called: …… Legal Name: ……

Date of Birth: …… / …… /…… Age: ……

Have you legally changed your name? □ Yes □ No If yes, when was the date: ……

Have you changed your gender on your IDs? □ Yes □ No

How do you identify?
□ woman □ man □ FTM □ MTF □ non-conforming □ genderqueer □ decline □ other: ……

Who is your support system?
□ significant other □ family □ friends □ therapist □ support group □ other: ……

Have you seen a medical or mental health provider about being transgender? □ Yes □ No

If yes, when were you first diagnosed or treated? ……

Have you obtained the necessary assessment letters from a medical or mental health provider? □ Yes □ No
Required letters: □ ONE hormone therapy letter documenting 12 months or more on hormones
□ ONE mental health provider letter from a psychiatrist or psychologist (PhD, MD)
□ ONE mental health provider letter from either a LMFT, LCSW, etc.

Have you started the hair removal process? □ Yes □ No If yes, how many sessions have you completed?……

Alcohol/Tobacco/Recreational drug use:

Current Recreational drugs: □ Yes □ No
If yes, what type and how often: ……

Prior history of recreational drug use: □ Yes □ No
If yes, what type: …… When did you start and quit? ……

Current Cigarettes: □ Yes □ No
If yes, packs per day: …… Cigarettes per day: ……

Prior history of cigarette/tobacco use: □ Yes □ No
If yes, packs/cigarettes per day: …… When did you start and quit?……

Current Inhalational drugs (vaping, marijuana, cigars, etc.): □ Yes □ No
If yes, what kind and how much: ……

Current Alcohol use: □ Yes □ No
If yes, how much: ……

Medical History:

Height: …… Weight: ……

Have you ever felt depressed? □ Yes □ No Have you ever felt suicidal or attempted suicide? □ Yes □ No

Hysterectomy consults only: Last pap smear: …… History of abnormal pap smear: □ Yes □ No

Patient Name: …… Date of Birth: ……. / ……. /……..

Please indicate what medical problems you have now or have had in the past:

Past	Present	Medical Problem	Comments/Approximate Dates
		Heart Disease	
		High Blood Pressure	
		Diabetes	
		Anemia	
		HIV or AIDS	
		HEP B or HEP C	
		Liver Disease	
		Kidney Disease	
		Thyroid Problems	
		Cancer	
		Stroke	
		COPD	
		Asthma	
		Other:	

Do you bruise easily or have any bleeding or blood clotting problems? □ Yes □ No
Do you have a history of hypertrophic scarring or keloids? □ Yes □ No

What medications do you take (including hormone therapy, vitamins, supplements, other)? Please provide the name, dosage, and directions (pill, injection, etc.). Please indicate what the medication is for.

Medication Name	Dosage	Directions	What is it for?

What operations have you had in the past?

Surgery Type	Date	Name of Surgeon

Have you or a relative ever had a bad reaction to general or local anesthesia? □ Yes □ No

If yes, what was the reaction? …….. Who had the reaction? ……..

Are you allergic to any medications? □ Yes □ No If yes, please list below:

Medication Name: …….. Reaction: ……..
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Are you allergic to latex? □ Yes □ No Are you allergic to shellfish? □ Yes □ No