



# MEDICAL INTAKE FORM AND CONSENT

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  transgender woman  transgender man  non-conforming  genderqueer  decline  .....

Who is your support system?

- significant other  family  friends  therapist  support group  .....

When did you start hormones? ..... Have you started hair removal (vulvo/vaginoplasty patients only)?  Yes  No

If yes, how many sessions have you completed? .....

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  TWO mental health letters from two separate mental health providers (qualified mental health providers with a doctoral or master’s level degree; PhD, MD, PsyD, LCSW, MSW, MFT, DSW, APRN, NP, LPC)

### 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: (Please complete ALL applicable fields)

**Height:** ..... (ft/in.) **Weight:** ..... (lbs.) **Waist circumference:** ..... (cm)

Have you ever felt suicidal or attempted suicide?  Yes  No

Do you currently have a mental health provider you see regularly?  Yes  No

Patient Name: .....

Date of Birth: ..... / ..... / .....

Hysterectomy consults only: Date of last pap smear: ..... History of abnormal pap smear:  Yes  No

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	
		Depression	
		Anxiety	
		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? (Please do not input future surgery dates)

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 latex?  Yes  No      Are you allergic to shellfish?  Yes  No

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

Medication Name: .....      Reaction: .....

Medication Name: .....      Reaction: .....

Medication Name: .....      Reaction: .....

PELVIC EXAMINATION CONSENT FORM

The Department of Health and Human Services requires written consent prior to performing a pelvic or rectal exam.

**CONSENT:** I, the below listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations by my physician or other health care providers at MoZaic Care, Inc who directly involved in my medical care.

**NATURE OF A PELVIC EXAM:** I understand that my medical care may require a physical or visual pelvic exam. A pelvic exam is defined as an examination of your pelvic organs using a gloved hand or instrument. These include your external genitals, such as the penis, testes, vulva, and your internal organs, such as the vagina, cervix, uterus and rectum.

**VALIDITY OF CONSENT:** The Patient, or the Patient’s legally authorized person, understands that this consent will remain valid from the date the Patient, or the Patient’s legally authorized person, dated this consent, unless otherwise revoked in writing by the Patient, or the Patient’s legally authorized person.

**I CONSENT TO RECEIVE A PELVIC EXAMINATION AS DESCRIBED ABOVE.**

Patient Name: ..... Patient Signature: ..... Date: .....

Witness Name: ..... Witness Signature: ..... Date: .....

Parent or Guardian Signature: ..... Date: .....

A parent of guardian must sign if the patient is under 18 years of age, except if the patient is an emancipated minor.