MOZAIC
MoZaic Care

MEDICAL INTAKE FORM

Date: ……..

Reason for Consultation: ……..

Preferred Name: …….. 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 ☐ 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
☐ TWO mental health provider letters (education level: PhD, MD or master's degree)

Alcohol use: ☐ Yes ☐ No Smoking: ☐ Yes ☐ No Recreational drugs: ☐ Yes ☐ No
If yes, how much: …….. If yes, how much: …….. If yes, what drug: ……..

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

Height: …… Weight: ..... Children? ☐ Yes ☐ No If yes, biologic? ☐ Yes ☐ No

What medical problems do you have now or have had in the past?

☐ Heart Disease ☐ High Blood Pressure ☐ Lung Disease/Asthma ☐ Diabetes ☐ Anemia
☐ HIV/AIDS ☐ Hep B / Hep C ☐ Liver Disease ☐ Kidney Disease
☐ Thyroid Problems ☐ 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
Do you have a urologist that you see for any urologic condition? ☐ Yes ☐ No
If yes, what condition(s)? ……..

What medications do you take (including hormone therapy, vitamins, supplements, other)? Please provide the name, dosage, and route (pill, injection, etc) of treatment. 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 Are you allergic to latex? □ Yes □ No

Medication Name: …… Reaction: ……
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