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**UCSF Transgender Care Patient Intake Form**

***Once this form is completed please fax it to Melina Lopez at (415) 353-2494. If you have any questions or concerns when completing this form, please call Melina Lopez at (415) 885-7770 or e-mail TransCare@ucsf.edu.***

**Today’s Date:** Click here to enter a date.

**Chosen Name:** Click here to enter text.

**Chosen pronoun:** Click here to enter text.

**Legal Name, if differs:** Click here to enter text.

**Date of Birth:** Click here to enter a date.

**Gender Identity:** Female ☐Male ☐Transgender Female ☐Transgender Male

☐Genderqueer/Gender Nonconforming/Nonbinary/Neither Male Nor Female

☐Gender Identity Not Listed Here (specify): Click here to enter text.

**Birth Assigned Sex:** ☐Female ☐Male

**Sexual Orientation:**  ☐Lesbian/Gay/Homosexual ☐Straight/Heterosexual

☐Bisexual/Pansexual/Queer ☐Sexual Orientation Not Listed Here (specify): Click here to enter text.

☐ Not Sure/Questioning

**Gender identitie(s) of sexual partner(s):**  ☐Male ☐Female ☐Non-binary transmasculine spectrum ☐Non-binary transfeminine spectrum: Click here to enter text. ☐ Not Sure/Questioning

**If applies to you:** Are any of your ☐ Male or ☐Female partners transgender?

**Do you require a translator?** Yes ☐ No ☐ If yes, what language? Click here to enter text.