



SEXUAL ORIENTATION GENDER IDENTITY (SOGI)

PATIENT NAME: _____ DOB: _____ DATE: _____

SEX ASSIGNED AT BIRTH	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unknown
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PRONOUNS

<input type="checkbox"/> he/him/his/his/himself	<input type="checkbox"/> co/co/cos/cos/cos
<input type="checkbox"/> she/her/her/hers/herself	<input type="checkbox"/> en/en/ens/ens/enself
<input type="checkbox"/> they/them/their/theirs/themselves	<input type="checkbox"/> ey/em/eir/eirs/emself
<input type="checkbox"/> ze/zir/zir/zirs/zirself	<input type="checkbox"/> yo/yo/yos/yos/yoself
<input type="checkbox"/> Xie/hir ("here")/hir/hirs/hirself	<input type="checkbox"/> ve/vis/ver/ver/verself

Another Pronoun, please specify: _____

SEXUAL ORIENTATION

<input type="checkbox"/>	Lesbian, gay, or homosexual
<input type="checkbox"/>	Straight or heterosexual
<input type="checkbox"/>	Bisexual
<input type="checkbox"/>	Do not know
<input type="checkbox"/>	Choose not to disclose

Something else, please describe: _____

GENDER IDENTITY

<input type="checkbox"/>	Male
<input type="checkbox"/>	Female
<input type="checkbox"/>	Female-to-Male (FTM) Transgender Male/Trans Man
<input type="checkbox"/>	Male-to-Female (MTF)/ Transgender Female/Trans Woman
<input type="checkbox"/>	Genderqueer, neither exclusively male nor female
<input type="checkbox"/>	Choose not to disclose

Additional gender category or other, please specify: _____