St. Thomas East End Medical Center Corporation
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"Your Health is our First Priority"

Gender Identification and Sexual Orientation Form

Date: _____

Last Name	First Name	Date of Birth

Please check the box appropriate in each category.

Gender Identification	Sexual Orientation
☐ Male	☐ Lesbian
☐ Female	☐ Gay
☐ Transgender Male/ Female to Male	☐ Heterosexual (Straight)
☐ Transgender Female/ Male to Female	☐ Bisexual
☐ Other _____	☐ Other _____
☐ Choose not to disclose	☐ Choose not to disclose

This information is mandated by Federal Government, reduces Health Disparities, and promotes culturally competent care. This information is not a mandate for patients under the age of 18. Please note your information will be strictly confidential.

Signature:_____

Official Use

Patient ID #_____ Date: _____

Staff Signature: _____