

**McLaren Print System Order**

Order No: 85727 Reprint Previous Order No: 85670  
 Order Date: 2024-05-23  
 User: Nicole Felton  
 Phone: 810-667-4149

Ship Location: McLaren Lapeer Medical Office Building Attn: Nicole Felton  
 1200 Barry Dr  
 Lapeer, MI 48446

**Forms**

Quantity: 100  
 Paragon Dept No: 50523  
 Dept Name: McLaren Lapeer Medical Office Building  
 Company Number: 810

Order Total Price: 3.35

Item Number: MMG-448  
 Item Description: SOGI Questionnaire  
 Revision Date: 05/2024  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: None  
 Misc Info: 8.5x11 SS Black



**Sexual Orientation and Gender Identity (SOGI) Questionnaire**

Patient name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
What are your pronouns?	Do you identify as transgender?
<input type="checkbox"/> Patient under age 18 (not required to ask)	<input type="checkbox"/> Patient under age 18 (not required to ask)
<input type="checkbox"/> He/him	<input type="checkbox"/> Yes
<input type="checkbox"/> She/her	<input type="checkbox"/> No
<input type="checkbox"/> They/them	<input type="checkbox"/> Prefer to describe (other)
<input type="checkbox"/> Prefer to describe (other)	<input type="checkbox"/> Prefer not to describe
<input type="checkbox"/> Prefer not to describe, other	<input type="checkbox"/> Other
How would you describe your gender identity?	Which do you think of your sexual orientation as?
<input type="checkbox"/> Patient under age 18 (not required to ask)	<input type="checkbox"/> Patient under age 18 (not required to ask)
<input type="checkbox"/> Man	<input type="checkbox"/> Straight or heterosexual
<input type="checkbox"/> Woman	<input type="checkbox"/> Lesbian, gay or homosexual
<input type="checkbox"/> Non-binary	<input type="checkbox"/> Bisexual
<input type="checkbox"/> Gender queer	<input type="checkbox"/> Pansexual
<input type="checkbox"/> Non-conforming gender	<input type="checkbox"/> Asexual
<input type="checkbox"/> Prefer to describe (other)	<input type="checkbox"/> Prefer to describe (other)
<input type="checkbox"/> Prefer not to describe	<input type="checkbox"/> Prefer not to describe
<input type="checkbox"/> Other	<input type="checkbox"/> Other
Who are your partners?	
<input type="checkbox"/> Patient under age 18 (not required to ask)	
<input type="checkbox"/> Male	
<input type="checkbox"/> Female	
<input type="checkbox"/> Non-binary	
<input type="checkbox"/> Transgender	
<input type="checkbox"/> Intense	
<input type="checkbox"/> Unknown	
<input type="checkbox"/> Prefer to describe	
<input type="checkbox"/> Prefer not to describe	
<input type="checkbox"/> Other	