

Mexico Transgender Center

Pre-Operative Medical History & Disclosures Intake Form

Instructions: Please complete this form truthfully and in its entirety. Your safety during anesthesia and surgery depends on our medical team having an accurate understanding of your health history.

Part 1: Patient Demographics & Procedure

- **Full Legal Name:** _____
- **Date of Birth:** _____ **Age:** _____
- **Planned Procedure (e.g., FFS, SRS):** _____
- **Surgeon:** Dr. Carlos Mendez Dr. Ivan Aguilar Other: _____
- **Emergency Contact Name:** _____
- **Emergency Contact Phone:** _____

Part 2: Medical & Surgical History

1. Have you ever been diagnosed with or treated for any of the following? (Check all that apply) High Blood Pressure Heart Disease / Arrhythmia / Pacemaker Bleeding or Clotting Disorders (e.g., Hemophilia, DVT) Asthma / COPD / Sleep Apnea Diabetes Liver or Kidney Disease HIV / Hepatitis B or C

2. Past Surgical History: Please list all previous surgeries and the approximate dates (including cosmetic and gender-affirming procedures):

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____

3. Anesthesia History: Have you or a blood relative ever had a severe reaction to anesthesia (e.g., Malignant Hyperthermia, prolonged intubation, severe nausea)? [] No [] Yes (Please explain): _____

Part 3: Medications & Allergies

1. Allergies: List all allergies to medications, latex, tape, or foods, and describe your reaction:

2. Current Medications & Supplements: List ALL prescription medications, over-the-counter drugs, vitamins, and herbal supplements you currently take. (*Note: Certain supplements and NSAIDs must be stopped 7-14 days prior to surgery due to bleeding risks.*)

_____ Dose: _____

3. Blood Thinners: Are you currently taking any blood thinners (e.g., Aspirin, Plavix, Warfarin, Eliquis)? [] No [] Yes

Part 4: Lifestyle & Social History

1. Tobacco & Nicotine: Do you currently smoke, vape, or use nicotine patches/gum? [] No [] Yes (Amount per day: _____) (*Note: Nicotine severely constricts blood vessels and can cause tissue necrosis. You must quit prior to surgery.*)

2. Alcohol: How many alcoholic beverages do you consume in an average week? _____

Part 5: Clinical Prohibition – Active Substance Abuse & Methadone Therapy

1. Explicit Prohibition of Surgery: The Mexico Transgender Center maintains strict medical safety protocols. Due to the extreme, life-threatening risks associated with general anesthesia and post-operative pain management, surgery is **strictly prohibited** for any individual who:

- Is currently engaging in the active abuse of illicit drugs (including but not limited to heroin, cocaine, methamphetamines, or non-prescribed opioids).
- Is currently enrolled in or utilizing Methadone therapy, Suboxone (buprenorphine), or any other opiate replacement/maintenance program.

2. Patient Declaration and Acknowledgment: By signing below, I affirmatively declare that I do not suffer from an active substance abuse disorder and that I am not currently taking Methadone or any opiate replacement medication. I understand that these substances severely alter the body's response to anesthesia, which can result in fatal respiratory depression, intraoperative awakening, or severe surgical complications.

3. Consequences of Falsification: I acknowledge that intentionally withholding or falsifying this critical medical information constitutes a breach of this agreement. If the medical staff discovers that I have concealed active drug addiction or current methadone use before, during, or immediately after the procedure, the clinic reserves the right to:

- Immediately cancel the surgery.
- Retain all deposits and surgical fees as a penalty for medical misrepresentation and securing operating room time under false pretenses.
- Discharge me from the facility immediately, releasing the clinic and its staff from all liability for any ensuing medical emergencies.

Part 6: Final Signature & Consent

I certify that I have read and understood this document and that the medical history provided is entirely accurate and complete. I understand that withholding information regarding my health, medications, or substance use severely jeopardizes my safety and survival during surgery.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____