New Patient Medical History and Intake Form

Name_____Date of Birth_____ Date of Exam_____
Social Security Number_____ Gender: □ Male □ Female
Address: _____City: _____ State _____ Zip Code _____
- E-mail: _____*(Must Have an Email)*

Home Phone:_____ Cell Phone: _____
□Married □Single □Divorced □Widower
Emergency Contact Name _____ Phone _____

Primary Care Physician _____
Address: Street: _____City: _____ State _____ Zip Code _____
Phone _____

Current Qualifying Medical Conditions for Medical Marijuana
Please Check the Primary Condition for Which Medical Marijuana is Requested

□ AIDS
□ Amyotrophic Lateral Sclerosis
□ Alzheimer's Disease
□ Cancer
□ Cachexia, Wasting Syndrome
□ Chronic Traumatic Encephalopathy
□ Crohn's Disease
□ Epilepsy or Another Seizure Disorder
□ Fibromyalgia
□ Glaucoma
□ Hepatitis C
□ Multiple Sclerosis
□ Parkinson's Disease
□ Positive Status for HIV
□ Post-Traumatic Stress Disorder
□ Sickle Cell Anemia
□ Spinal Cord Disease or Injury
□ Tourette's Syndrome
□ Traumatic Brain Injury
□ Ulcerative Colitis
□ Inflammatory Bowel Disease
□ Pain that is Either Chronic and Severe or Intractable: *Location of Pain*_____

Describe Your Current Qualifying Medical Condition:_____
_____
_____

Past Medical History: *Please note if you have had any of the following Medical Illnesses / Problems*

□ Arthritis	□ Anxiety Disorder	□ Chronic Pain	□ Depression
□ Diabetes	□ Head Injury	□ Heart Disease	□ High Blood Pressure
□ Hepatitis C	□ Hyperthyroid	□ Kidney disease	□ Liver disease
□ Osteoporosis	□ Seizures	□ Sleep apnea	□ Multiple sclerosis
□ Stroke	□ Ulcers	□ Gout	□ Rheumatoid Arthritis
□ Lupus	□ Bipolar Disorder	□ Schizophrenia	□ COPD
□ Hypertension	□ Arthritis	□ Other_____	

Are you pregnant? □ Yes □ No □ Unsure Date of last period: _____
(If Applicable, Women of Childbearing Age Must Answer)

Surgical History: *Please note if you have had any surgeries and write date*
□ None □ Surgery _____ Date: _____
_____Date:_____
_____Date:_____

_____Date:_____

Hospitalization History: *Please note if you have had any Hospitalizations and write date*
□ None □ Hospital _____ Date: _____
_____Date:_____
_____Date:_____
_____Date:_____

Social History: Are you currently employed? YES NO What type of work? _____
If you are no longer working why did you stop and do you expect to return to work? _____
_____

Are you on Disability? (start date)_____On Workmen's Compensation?(start date)_____
Do you have any pending legal matters relating to your medical condition? YES NO

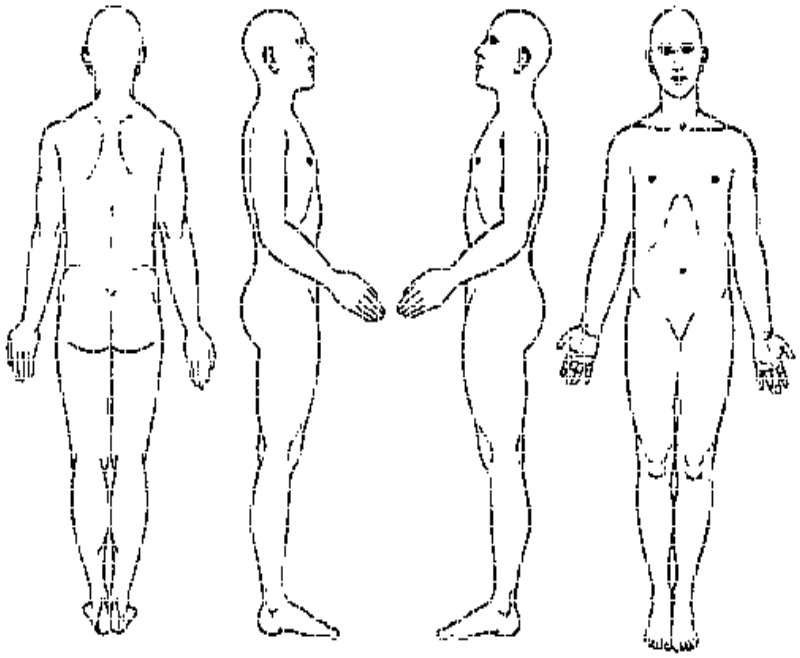
Are you on parole or probation or have a pending cannabis legal problem: YES NO

Smoking History: □ No □ Ex-Smoker □ Current Drinking History: □No □ Ex-Drinker □ Current
Drug Use: □No □Past □Current □Cocaine □Marijuana □Heroin □Other_____
Have you ever been addicted to prescription drugs YES NO

Psychiatric History: NO YES Have you seen: □ Psychiatrist □ Psychologist □ Social Worker
Do you have a direct blood relative (father, mother, siblings) that have had symptoms or has been diagnosed as having schizophrenia or has been psychotic YES NO

Cannabis History: Are you currently using medical marijuana? YES NO Dr._____
When did you start? Frequency of Use: □ daily □ weekly □ monthly
Does cannabis provide relief from your medical symptoms/problem? YES NO

On Diagram Below Please Mark the Areas Where You Have Pain
Use the symbols to indicate where your pain is:
Moderate Pain =O Severe Pain = X Numbness = N Ache= A



1. How would you assess your pain now, at this moment?
   None 0 1 2 3 4 5 6 7 8 9 10 Max
2. How strong was the strongest pain during the past 4 weeks?
   None 0 1 2 3 4 5 6 7 8 9 10 Max
3. How strong was the pain during the past 4 weeks on average?
   None 0 1 2 3 4 5 6 7 8 9 10 Max
4. Walking Ability from Pain?
   None 0 1 2 3 4 5 6 7 8 9 10 Max
5. Sleep related to Pain?
   None 0 1 2 3 4 5 6 7 8 9 10 Max
6. Enjoyment of Life?
   None 0 1 2 3 4 5 6 7 8 9 10 Max

Review of Systems Checklist: (*please check all that apply to your current condition)*

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Swollen glands
□ Pain
□ Self-exams
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Name_____DOB_____DATE_____

Mood Assessment Questionnaire

The questions you are about to answer will help assess your mood.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative and/or spoke much faster than usual?	☐	☐
...thoughts raced through your head and/or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active and/or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual - for example, you telephoned friends in the middle of the night?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐

	YES	NO
2. If you checked **YES** to more than one of the above, have you experienced several of these during the same period of time?	☐	☐

3. How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

Two Questions About Yourself

	YES	NO
1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐	☐
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐

Medical Marijuana Medication Flow Sheet

Name:_____ DOB_____Date of Exam_____

Allergies:

Date Started	Medication/Supplements/Herbs/OTC	Remark

PHYSICIAN USE ONLY:

Reviewed OARRS (12 months from Date) YES NO Comments_____

Patient on : Benzodiazepine YES NO Opiods YES NO Review Medications Potential Side Effects YES NO
Outcome of these Medications:_____

Reviewed Possible Drug Interactions with Marijuana from Medications on Flow Sheet YES NO
Comments_____

Reviewed History of Drug Abuse YES NO Consult for Drug Abuse Recommended YES NO

Any Indication of Possible Abuse or Diversion of Controlled Substances from OARRS Report or Behavioral Indications YES NO Comment_____

ORDER DRUG SCREEN YES NO