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THC PATIENT HISTORY FORM

Patient Name: _____

DOB: _____ **Date:** _____

Please complete this form to the best of your knowledge. If a question does not apply, leave it blank.

MEDICAL HISTORY

Qualifying Medical Condition(s):

Past Medical History: (e.g., diabetes, high blood pressure, chronic pain, anxiety, PTSD, etc.):

Surgical History:

Current Prescription & Over-the-Counter Medications:

Medication Allergies:

SUBSTANCE USE HISTORY

Tobacco Use (type & frequency):

Alcohol Use (type & frequency):

Illicit/Recreational Drug Use (type & frequency):

Prior Cannabis Use (before medical certification):

☐ None ☐ Rare ☐ Occasional ☐ Regular

If yes, describe: _____

CANNABIS TREATMENT HISTORY

Form(s) of cannabis used:

☐ Flower ☐ Vape ☐ Edible ☐ Oil/Tincture ☐ Topical ☐ Other: _____

Dosage/Frequency:

How effective is cannabis in treating your condition?

☐ Not at all ☐ Mild ☐ Moderate ☐ Significant

Side effects experienced (if any):

Have you adjusted your use due to side effects?

☐ Yes ☐ No

If yes, explain: _____

OVERALL TREATMENT EFFECTIVENESS

Other current treatments (medications, therapy, etc.):

How effective are these treatments?

☐ Not at all ☐ Mild ☐ Moderate ☐ Significant

PATIENT ATTESTATION

I certify that the above information is true and accurate to the best of my knowledge.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____