

## Dr. Rasean T. Hodge - Patient Intake Form

Thank you for your trust and support. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). Please keep in mind that your visit either in our office or via telemedicine, will consist of a consult to discuss Medicinal Cannabis and how it can help treat those symptoms caused by your current illness. A review of your medical records will be reviewed, prior to your appointment to confirm your eligibility in the program. This visit is not to replace your present care received by your treating physician. You should still continue treatment with your current provider to stay up to date with any testing, labs, or procedures which may be required from you. Your treatment here in my office is specific to only your condition and its relation to treatment with the use of the Low THC Oil. My office as a result of your registering for the Medicinal Cannabis card, will not complete any reports relating to your inability to perform any job duties, requests for time off, social security, long term/short term disability, workers compensation, or any other monetary benefit. You should seek assistance from your current healthcare provider to complete any and all such forms.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

What is your qualifying illness? \_\_\_\_\_

When were you diagnosed? Month: \_\_\_\_\_ Year: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How long have you lived in the state of Georgia? \_\_\_\_\_

Sex: M      F      Other \_\_\_\_\_ Race: \_\_\_\_\_

Email address \_\_\_\_\_

Home Tel (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to leave a message?    Y    N

Work Tel (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to leave a message?    Y    N

Cell Tel (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK to leave a message?    Y    N

Medical History Please check all that apply

- Emphysema
- Tuberculosis
- Pneumonia
- Bronchitis
- Asthma
- Allergies
- Heart Disease
- Stroke
- High Blood Pressure
- Elevated Cholesterol
- Diabetes
- Venous Thrombosis
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Cirrhosis
- Anemia
- Thyroid Trouble
- Gallbladder Disease

- Ulcers
- Frequent Urinary Tract Infections
- Sexually Transmitted Infections
- Prostate Trouble
- Cancer
- Arthritis
- Osteoporosis
- Fractures
- Migraines
- Depression
- Anxiety or Panic Disorder
- Posttraumatic Stress Disorder
- Alcohol or Substance Use Problem

Other: \_\_\_\_\_

## Systems Review

Please check any of the following symptoms that you have recently experienced or are a concern to you.

### General:

recent weight loss  recent weight gain  fatigue  fever  
 changes in appetite  night sweats

Skin:  rashes  lumps  itching  dryness  color change  
 hair or nail change

Head:  headaches  head injuries  dizziness

Eyes: Date of last exam: \_\_\_/\_\_\_/\_\_\_

glasses  contacts  pain  double vision  redness  
 glaucoma  cataracts Nose:  frequent colds  nasal stuffiness  
 hay fever  nosebleeds  sinus trouble  dust/animal allergies

### Ears:

hearing loss

Mouth & Throat:

Date of last dental exam: \_\_\_/\_\_\_/\_\_\_

\_\_\_ bleeding gums \_\_\_ frequent sore throats \_\_\_ hoarseness

Neck: \_\_\_ goiter \_\_\_ lumps/swollen glands \_\_\_ pain

Breasts: (if applicable)

Date of last mammogram: \_\_\_/\_\_\_/\_\_\_

\_\_\_ lumps \_\_\_ pain \_\_\_ nipple discharge

Respiratory: \_\_\_ cough \_\_\_ wheezing \_\_\_ shortness of breath  
\_\_\_ coughing up blood

Cardiac: \_\_\_ heart murmur \_\_\_ chest pain \_\_\_ palpitations \_\_\_ swelling of  
feet \_\_\_ shortness of breath

Gastrointestinal: \_\_\_ trouble swallowing \_\_\_ heartburn or gas  
\_\_\_ nausea \_\_\_ vomiting \_\_\_ rectal bleeding \_\_\_ constipation  
\_\_\_ diarrhea \_\_\_ abdominal pain \_\_\_ hemorrhoids \_\_\_ jaundice (skin or  
whites of eyes turning yellow)

Urinary: \_\_\_ frequent urination \_\_\_ painful urination \_\_\_ blood in urine  
\_\_\_ stones \_\_\_ difficulty urinating or difficulty holding urination  
\_\_\_ waking up to go to the bathroom several times at night

Musculoskeletal: \_\_\_ joint stiffness \_\_\_ arthritis \_\_\_ gout \_\_\_ backache  
\_\_\_ muscle pains \_\_\_ muscle cramps

Peripheral Vascular: \_\_\_ leg cramps while walking \_\_\_ varicose veins  
\_\_\_ thrombophlebitis Neurological: \_\_\_ fainting \_\_\_ blackouts  
\_\_\_ seizures \_\_\_ weakness \_\_\_ numbness \_\_\_ tremors \_\_\_ tingling hands  
or feet \_\_\_ change in memory

Psychiatric/Psychological: \_\_\_ anxiety \_\_\_ depression \_\_\_ phobias  
\_\_\_ family problems \_\_\_ eating disorder

Hematologic: \_\_\_ anemia \_\_\_ easy bruising or bleeding \_\_\_ blood  
transfusions: Year(s) \_\_\_\_\_

Endocrine: \_\_\_ heat or cold intolerance \_\_\_ excessive sweating  
\_\_\_ excessive hunger \_\_\_ excessive urinating

Do you experience chronic pain? Yes No If YES, how is your pain managed (ie, physical therapy, medication, etc)?

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On a scale of zero to ten, with ten being the worst and zero being no pain, how would you rate your current pain? \_\_\_\_\_

Operations and/or Hospitalizations: (Please list surgeries and/or hospitalization reasons and dates)

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Current Medications: (Please include any non-prescription drugs as well, eg, vitamins, aspirin, etc.) Medication Name Dose Frequency of Use

1. \_\_\_\_\_

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2. \_\_\_\_\_

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3. \_\_\_\_\_

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If you need more room, please list additional medications on bottom of last page.

Allergies: (Please list any allergies you may have to medications and food)

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