Please return completed forms via fax to 888.291.6290 or email to info@premiercpc.com

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 and/or ability 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.

Signature: _____

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)?

_____

_____

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)

_____

_____

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

1. _____ _____
_____
2. _____ _____
_____
3. _____ _____
_____

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)

_____