Please complete this form and either email it to admin@greendoctors.co.nz or bring it with you to the clinic

Name:	**GP:**
Address:	**GP Medical Practice:**
DOB:	**NHI (if known):**
Phone number:	**Date of consultation:**

DO YOU GIVE US CONSENT TO ACCESS YOUR HOSPITAL MEDICAL RECORDS? **YES** **NO**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Heart Disease	**YES**	**NO**	Phaeochromocytoma	**YES**	**NO**
Lung Disease	**YES**	**NO**	Thyroid disease	**YES**	**NO**
Diabetes	**YES**	**NO**	High blood pressure	**YES**	**NO**

DO YOU SUFFER FROM ANY OF THE FOLLOWING SYMPTOMS?

Headaches	**YES**	**NO**
Palpitations	**YES**	**NO**
Sweating	**YES**	**NO**

WHAT IS THE MAIN REASON YOU'RE WANTING MEDICINAL CANNABIS? for eg pain/anxiety/sleep?

PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE? For eg Diabetes, Epilepsy, Anxiety etc

PLEASE LIST ANY MEDICATIONS YOU'RE TAKING? (If so, please list them)

ARE YOU ALLERGIC TO ANY MEDICATIONS? (If so, please list them)

Have you or anyone in your family ever been diagnosed with Schizophrenia?		**YES**	**NO**
Have you or anyone in your family ever had a Psychotic episode?		**YES**	**NO**
Are you pregnant?	**N/A**	**YES**	**NO**
Do you have a history of addiction or substance abuse?		**YES**	**NO**
Do you use cannabis on a regular basis?		**YES**	**NO**
Has cannabis use ever made you paranoid or psychotic?	**N/A**	**YES**	**NO**
Have you ever used cannabis before?		**YES**	**NO**

DO YOU SMOKE CIGARETTES? **YES** **NO**

DO YOU DRINK ALCOHOL? **YES** **NO**

If so, how many standard drinks would you have in an average week?