Medical Card Assessment Form

Maple Valley Pharms

Please be sure to complete ALL fields.

Are you applying for recertification? Y / N

Date of Consultation: _____ Date of Birth: _____

First Name/Last Name: _____

Address: _____ City/State: _____ Zipcode: _____

Phone Number: _____ Email Address: _____

What is your primary complaint (what is the reason you are applying)?

_____

_____

_____

1. Does the patient have a severe cardiac condition? Y / N
2. Does the patient smoke tobacco? Y / N - if so, how many per day? _____
3. Does the patient drink alcohol? Y / N - if so, how much per week? _____
4. Does the patient use illicit drugs (non-cannabis)? Y / N
5. Does the patient have a history of substance abuse? Y / N
6. If the patient answered yes to #5, has the patient completed a drug screen? Y / N
7. Does the patient have a family history of psychosis? Y / N
8. Does the patient have a family history of schizophrenia? Y / N
9. Does the patient have any family history of major cardiac conditions? Y / N
10. Is the patient pregnant or nursing? Y / N

Current Medications:

Past Medications (no longer taking):

Has the patient tried alternative therapies in the past? Y / N If so, what type?

Patient's Past Surgical History:

Patient's Past Hospitalization/Serious Illness:

Does the patient have allergies? Y / N If yes, to what?

Does the patient have experience with cannabis? Y / N

Does the patient use daily, weekly, monthly, or past use? (circle one)

What methods of consumption does the patient currently use? (circle all that apply)

Smoke Vaporize Edible Tincture Topical Transdermal

What positive effects has the patient experienced with cannabis use?

Has the patient experienced any negative side effects to cannabis? If so, please specify:

For Budtender Use Only