Affinity
BOTANICAL MEDICINE

Jason H. Bredenkamp, M.D.
1215 Southtown Blvd, Ste 303
Owensboro, KY 42301
(270) 570 - 9535

NEW PATIENT DEMOGRAPHICS & HEALTH HISTORY

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

DOB | If minor, name of responsible parent

SSN | **KY DL/ID #**

Address | **City/State** | **Zip Code**

Phone # | **Email Address**

TYPE OF REGISTRATION

☐ In-state Qualified Patient ☐ Visiting Qualified Patient ☐ Designated Caregiver

PRIMARY REASON FOR VISIT TODAY

☐ Chronic or Severe Pain ☐ Cancer ☐ Multiple Sclerosis (MS) ☐ Epilepsy or Seizure Disorder

☐ Cyclic Vomiting Syndrome ☐ Chronic Nausea ☐ Muscle Spasms/Muscle Spasticity ☐ Post-Traumatic Stress Disorder (PTSD)

☐ Other:

CURRENT PRIMARY CARE PROVIDER

Physician Name	
Practice Name	
Practice Location	

Did you bring copies of your medical records with you today? ☐ **Yes** ☐ **No**

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PERSONAL MEDICAL HISTORY

Constitutional *e.g., fever, heat stroke, weight loss, weight gain, unusually tired, etc.*

☐ YES Comments:

☐ No

Ear/Nose/Throat *e.g., hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*

☐ YES Comments:

☐ No

Heart (Cardiovascular) *e.g., high blood pressure, racing pulse, chest pain, unable to exercise, etc.*

☐ YES Comments:

☐ No

Lungs (Respiratory) *e.g., congestion, wheezing, shortness of breath, productive or bloody cough, asthma, etc.*

☐ YES Comments:

☐ No

Digestion (Gastrointestinal) *e.g., stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*

☐ YES Comments:

☐ No

Muscles and bones (Musculoskeletal) *e.g., muscle pain/cramps, joint pain swelling, stiffness, etc.*

☐ YES Comments:

☐ No

Urological *e.g., painful or frequent urination, burning, impotence, incontinence, infections, etc.*

☐ YES Comments:

☐ No

Neurological *e.g., numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*

☐ YES Comments:

☐ No

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Psychiatric *e.g., depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*

☐ YES Comments:

☐ No

Blood/Lymphatic *e.g., high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*

☐ YES Comments:

☐ No

Skin *e.g., itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc.*

☐ YES Comments:

☐ No

Cancer

☐ YES Comments:

☐ No

Allergic/Immunologic *e.g., recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc.*

☐ YES Comments:

☐ No

Hormones (Endocrine) *e.g., diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*

☐ YES Comments:

☐ No

Gynecological *e.g., pregnancies, menstrual problems, ovarian and uterine conditions, etc.*

☐ YES Comments:

☐ No

Breast *e.g., cysts, fibroids, pain, numbness, lumps, etc.*

☐ YES Comments:

☐ No

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MAJOR ILLNESSES/HOSPITALIZATIONS

☐ Yes ☐ No

SURGERIES

ALLERGIES *List ALL allergies, severity, and reaction*

MEDICATIONS

List ALL medications you are CURRENTLY taking (include all herbals, vitamins, & supplements)

Medication	Dose	Frequency

IF MEDICATION LIST GOES BEYOND THE SPACE PROVIDED, THEN PLEASE ATTACH A SEPARATE SHEET

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RELEVANT FAMILY HISTORY

Parents, Siblings, or Grandparents only

Diabetes	☐	Cancer	☐	Other (Please List):
Heart Disease	☐	High Blood Pressure	☐	
Arthritis	☐	Psychiatric History	☐	
Neurological Conditions	☐	Autoimmune Disorders	☐	

PERSONAL SOCIAL HISTORY

Tobacco use?

☐ Never
☐ Current everyday use
☐ Current intermittent use
☐ Former use

Alcohol use?

☐ Never
☐ Current everyday use
☐ Current intermittent use
☐ Former use

Recreational drug use?

☐ Never
☐ Current everyday use
☐ Current intermittent use
☐ Former use

Other:

Have you ever been convicted of a felony that could cause you to be ineligible for the KY medical cannabis program?

☐ YES
☐ NO
☐ Unsure

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EMERGENCY CONTACTS (PLEASE PROVIDE AT LEAST 1 CONTACT)			
Name		**Relationship**	**Phone #**
Address	**City**	**State**	**ZIP**
Name		**Relationship**	**Phone #**
Address	**City**	**State**	**ZIP**

PATIENT REFERRAL INFORMATION			
Patient referred by*			**Phone #**
Address	**City**	**State**	**ZIP**

PATIENT ACKNOWLEDGMENT & DISCLAIMER

By completing this intake form, you acknowledge that the information provided is accurate and truthful to the best of your knowledge. Affinity Botanical Medicine operates in compliance with Kentucky law, and our services are intended to assist qualifying patients in accessing medical cannabis recommendations as permitted by state regulations. Completion of this form and any subsequent consultation with Affinity Botanical Medicine does not guarantee approval for the Kentucky Medical Cannabis Program. Affinity Botanical Medicine does not dispense or sell medical cannabis products; we solely provide evaluation and recommendation services. All information shared with Affinity Botanical Medicine will be kept confidential and used solely for the purpose of determining eligibility for a written medical cannabis certification, in accordance with HIPAA and applicable privacy laws. The evaluation provided is solely for determining eligibility for the Kentucky medical cannabis program in compliance with state law. Affinity Botanical Medicine is not liable for any adverse effects, side effects, or complications arising from the use of medical cannabis, including but not limited to physical, psychological, or legal consequences. It is the patient's responsibility to use medical cannabis in accordance with Kentucky law and any provider recommendations.

Patient signature: _____ **Date:** _____