:

Green Rx Cher Aymond MD

PAST MEDICAL HISTORY

PATIENT	DATE OF BIRTH
EMAIL ADDRESS	CELL PHONE
PREFERRED CONTACT METHOD ☐ TEXT ☐ PHONE ☐ EMAIL	LOUISIANA DRIVERS IDENTIFICATION # OR STATE ISSUED ID #

List any medications and dosage you are currently taking (prescription and non-prescription) please use blank page if needed:

NAME *Example: Aspirin*	**DOSAGE** *325 mg*	**FREQUENCY** *Once a day*	**DOCTOR** *Doctor's Name*

Please list any drug allergies and describe (prescription and non-prescription):

Please check ✓ if any of the following activities are substantially limited or impaired

	Bending		Breathing
	Caring for myself		Communicating
	Concentrating		Eating
	Lifting		Operation of major bodily functions
	Performing manual task		Reading
	Seeing		Sleeping
	Social Interaction		Speaking
	Standing		Thinking
	Walking		Working

Please list any additional information you consider relevant to the physician's evaluation

Please list any Surgical History

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Do you require assistance in activities of Daily Living ☐ Requires No Assistance ☐ Some Assistance Needed ☐ Complete Assistance Needed
Are you currently taking CBD Oil? ☐ Yes ☐ NO If yes, Do you experience any side effects from CDB ? ☐ Yes ☐ NO
List any Side Effects:

Please circle the current symptom(s) you may have, you may select multiple options

Abdominal Pain	Mild	Moderate	Severe
Anxiety	Mild	Moderate	Severe
Joint Pain	Mild	Moderate	Severe
Muscle Spasm	Mild	Moderate	Severe
Poor Appetite	Mild	Moderate	Severe
Nausea / Vomiting	Mild	Moderate	Severe
Disturbing Feelings	Mild	Moderate	Severe
Depression	Mild	Moderate	Severe
Constipation	Mild	Moderate	Severe

Please check ✓ Yes of No

	YES	NO
Do you smoke tobacco		
Do you understand smoking is harmful to your lungs and is not medically advised		
Have you used Cannabis in the past to treat your medical condition(s)		
Have you had any negative / adverse reactions from cannabis use		
If yes, Please specify:		
Do you have a history of addiction and / or drug abuse		
If yes, Please specify the drug(s):		
Do you have a history of mental Illness		
Do you have a history of mental illness in your immediate family, Parents, Grandparents, Brother / Sister		
If yes, Please specify condition(s):		

Please check ✓ preferred method of marijuana uses as a medicine

Preferred Treatment Method	✓	Preferred Treatment Method	✓
Capsules		Nebulizer (in future)	
Oil Extract / Concentrate		Tincture	
Topical Cream		Vaporizer (in future)	
Other:			

Please circle your level of pain

1	2	3	4	5	6	7	8	9	10

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining or distributing medical marijuana.

I attest that I am not a member, employer, or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone, or any other recording device be it a still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality.

I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition, my intentions or falsified a medical record to the physician.

I acknowledge Cher Aymond MD informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success of failure.

I acknowledge Cher Aymond MD informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my conditions.

Patient Signature _____ **Date** _____

Release of Liability

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief an improvement in my condition.

In requesting approval or recommendation for the use of medical marijuana, I assume full responsibility for any and all risks involved in this action.

I was also advised that the use of medical marijuana might affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis s a medicine has been explained to me and that ay questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physical to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone action on my behalf, hold the physician and his/her principals, agents, and employees, free of an harmless from any liability resulting from the use of medical marijuana.

Patient Signature _____ **Date** _____