**New Patient Medical History and Intake Form**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_ Date of Exam\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □ Male □ Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

● E-mail: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Must Have an Email)*

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□Married □Single □Divorced □Widower

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Qualifying Medical Conditions for Medical Marijuana**

*Please Check the Primary Condition for Which Medical Marijuana is Requested*

□ Multiple Sclerosis

□ Parkinson’s Disease

□ Positive Status for HIV

□ Post-Traumatic Stress Disorder

□ Sickle Cell Anemia

□ Spinal Cord Disease or Injury

□ Tourette’s Syndrome

□ Traumatic Brain Injury

□ Ulcerative Colitis

□ Inflammatory Bowel Disease

□ AIDS

□ Amyotrophic Lateral Sclerosis

□ Alzheimer’s Disease

□ Cancer

□ Chronic Traumatic Encephalopathy

□ Crohn’s Disease

□ Epilepsy or Another Seizure Disorder

□ Fibromyalgia

□ Glaucoma

□ Hepatitis C

□ Pain that is Either Chronic and Severe or Intractable: *Location of Pain*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe Your Current Qualifying Medical Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:** *Please note if you have had any of the following Medical Illnesses / Problems*

□ Arthritis □ Anxiety Disorder □ Chronic Pain □ Depression

□ Diabetes □ Head Injury □ Heart Disease □ High Blood Pressure

□ Hepatitis C □ Hyperthyroid □ Kidney disease □ Liver disease

□ Osteoporosis □ Seizures □ Sleep apnea □ Multiple sclerosis

□ Stroke □ Ulcers □ Gout □ Rheumatoid Arthritis

□ Lupus □ Bipolar Disorder □ Schizophrenia □ COPD

□ Hypertension □ Arthritis □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? □ Yes □ No □ Unsure Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If Applicable, Women of Childbearing Age Must Answer)*

**Surgical History:** *Please note if you have had any surgeries and write date*

**□** None □ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 1

**Hospitalization History:**  *Please note if you have had any Hospitalizations and write date*

**□** None □ Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** Are you currently employed? YES NO What type of work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are no longer working why did you stop and do you expect to return to work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on Disability? (start date)\_\_\_\_\_\_\_\_\_\_\_\_On Workmen’s Compensation?(start date)\_\_\_\_\_\_\_\_\_\_\_

Do you have any pending legal matters relating to your medical condition? YES NO

Are you on parole or probation or have a pending cannabis legal problem: YES NO

Smoking History: □ No □ Ex-Smoker □ Current Drinking History: □No □ Ex-Drinker □ Current

Drug Use: □No □Past □Current □Cocaine □Marijuana □Heroin □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been addicted to prescription drugs YES NO

**Psychiatric History**: NO YES Have you seen: □ Psychiatrist □ Psychologist □ Social Worker

Do you have a direct blood relative (father, mother, siblings) that have had symptoms or has been diagnosed as having schizophrenia or has been psychotic YES NO

**Cannabis History:** Are you currently using medical marijuana? YES NO Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you start? Frequency of Use: □ daily □ weekly □ monthly

Does cannabis provide relief from your medical symptoms/problem? YES NO

**On Diagram Below Please Mark the Areas Where You Have Pain**

*Use the symbols to indicate where your pain is:*

**Moderate Pain =O Severe Pain = X Numbness = N Ache= A**



1. How would you assess your pain now,

at this moment?

None 0 1 2 3 4 5 6 7 8 9 10 Max

2. How strong was the strongest pain

during the past 4 weeks?

None 0 1 2 3 4 5 6 7 8 9 10 Max

3. How strong was the pain during the

past 4 weeks on average?

None 0 1 2 3 4 5 6 7 8 9 10 Max

4. Walking Ability from Pain?

None 0 1 2 3 4 5 6 7 8 9 10 Max

5. Sleep related to Pain?

None 0 1 2 3 4 5 6 7 8 9 10 Max

6. Enjoyment of Life?

None 0 1 2 3 4 5 6 7 8 9 10 Max

Page 2

**Review of Systems Checklist: (***please check all that apply to your current condition)*

**General-**

□ Dry mouth

□ Sore throat

□ Hoarseness

□ Thrush

□ Non-healing sores

**Neck-**

□ Lumps

□ Stiffness

**Breasts-**

□ Lumps

□ Pain

□ Discharge

□ Swollen glands

□ Pain

□ Self-exams

□ Breast-feeding

**Respiratory-**

□ Cough

□ Sputum

□ Coughing up blood

□ Shortness of breath

□ Wheezing

□ Painful breathing

**Cardiovascular-**

□ Chest pain or discomfort

□ Tightness

□ Palpitations

□ Shortness of breath with activity

□ Difficulty breathing lying

down

□ Swelling

□ Sudden awakening from sleep

with shortness of breath

**Gastrointestinal-**

□ Swallowing difficulties

□ Heartburn

□ Change in appetite

□ Nausea

□ Change in bowel habits

□ Rectal bleeding

□ Constipation

□ Diarrhea

□Yellow eyes or skin

**Urinary-**

□ Frequency

□ Urgency

□ Burning or pain

□ Blood in urine

□ Incontinence

□ Change in urinary strength

**Vascular-**

□ Calf pain with walking

□ Leg cramping

**Musculoskeletal-**

□ Muscle or joint pain

□ Stiffness

□ Back pain

□ Redness of joints

□ Swelling of joints

□ Trauma

**Neurologic-**

□ Dizziness

□ Fainting

□ Seizures

□ Weakness

□ Numbness

□ Tingling

□ Tremor

**Hematologic-**

□ Ease of bruising

□ Ease of bleeding

**Endocrine-**

□ Head or cold intolerance

□ Sweating

□ Frequent urination

□ Thirst

□ Change in appetite

**Psychiatric-**

□ Nervousness

□ Stress

□ Depression

□ Memory loss

□ Weight loss or gain

□ Fatigue

□ Fever or chills

□ Weakness

□ Trouble sleeping

**Skin-**

□ Rashes

□ Lumps

□ Itching

□ Dryness

□ Color changes

□ Hair and nail changes

**Head-**

□ Headache

**□** Head injury

**□** Neck Pain

**Ears-**

□ Decreased hearing

□ Ringing in ears

□ Earache

□ Drainage

**Eyes-**

□ Vision Loss/Changes

□ Glasses or contacts

□ Pain

□ Redness

□ Blurry or double vision

□ Flashing lights

□ Specks

□ Glaucoma

□ Cataracts

□ Last eye exam

**Nose-**

□ Stuffiness

□ Discharge

□ Itching

□ Hay fever

□ Nosebleeds

□ Sinus pain

**Throat-**

□ Bleeding

□ Dentures

□ Sore tongue

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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_

**Mood Assessment Questionnaire**

The questions you are about to answer will help assess your mood.

1. Has there ever been a period of time when you were not your usual self and**... YES NO**

...you felt so good or so hyper that other people thought you were not your normal

self, or you were so hyper that you got into trouble?  **□ □**

...you were so irritable that you shouted at people or started fights or arguments  **□ □**

...you felt much more self-confident than usual? **□**   **□**

...you got much less sleep than usual and found you didn't really miss it? **□ □**

...you were much more talkative and/or spoke much faster than usual? **□ □**

...thoughts raced through your head and/or you couldn't slow your mind down? **□ □**

...you were so easily distracted by things around you that you had trouble concentrating or

staying on track? **□ □**

...you had much more energy than usual? **□ □**

...you were much more active and/or did many more things than usual?  **□ □**

...you were much more social or outgoing than usual - for example, you telephoned friends

in the middle of the night? **□ □**

...you did things that were unusual for you or that other people might have thought were

excessive, foolish, or risky? **□ □**

...spending money got you or your family into trouble? **□**   **□**

**YES NO**

2. If you checked **YES** to more than one of the above, have you experienced several

of these during the same period of time? **□ □**

3. How much of a problem did any of these situations cause you (like being unable to work; having

family, money, or legal problems; and/or getting into serious arguments or fights)?

**□** No Problem **□** Minor Problem **□** Moderate Problem **□** Serious Problem

**Two Questions About Yourself**

**YES NO**

1. During the past month, have you often been bothered by feeling down,

depressed, or hopeless? **□ □**

2. During the past month, have you often been bothered by little interest or

pleasure in doing things? **□ □**

Page 4

**Medical Marijuana Medication Flow Sheet**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_Date of Exam\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Allergies:** | |  |  |  |  |  |
| **Date Started** | **Medication/Supplements/Herbs/OTC** | | | **Remark** | | |
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**PHYSICIAN USE ONLY:**

Reviewed OARRS (12 months from Date) YES NO Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient on : Benzodiazepine YES NO Opiods YES NO Review Medications Potential Side Effects YES NO

Outcome of these Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed Possible Drug Interactions with Marijuana from Medications on Flow Sheet YES NO Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed History of Drug Abuse YES NO Consult for Drug Abuse Recommended YES NO

Any Indication of Possible Abuse or Diversion of Controlled Substances from OARRS Report or Behavioral Indications YES NO Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORDER DRUG SCREEN YES NO Page 5