PATIENT MEDICAL HISTORY INTAKE FORM

Name: ____ DOB: _____________ SS#: _______________

Gender: ____ Male ____ Female Phone: __________________ Email: _____________________

Street Address: ____

City: ___________________ State: __________________ Zip Code: ___________

How did you hear about us? ____

For what conditions do you seek medical cannabis? ____

Please list all doctors, including their name, address and phone number that you have seen in the last five years for any condition related to your current health and your request for medical cannabis:

Doctor Name	Address	Phone Number	Reason for Visit

Past Medical History (Please mark all that apply):

_____ AIDS	_____ IBS	_____ Anorexia
_____ ALS	_____ HIV	_____ Bulimia
_____ Alzheimer's Disease	_____ Auto-immune Disorder	_____ Brain disorders
_____ Intestinal Disorder	_____ Blood Disorders	_____ Prostate Disease
_____ Ulcers	_____ Disc Injury	_____ Hearing Loss
_____ Colitis	_____ Osteoporosis	_____ Tinnitus
_____ Crohn's Disease	_____ Scoliosis	_____ Epilepsy/Seizures/Spasms
_____ Cachexia/Wasting Syndrome	_____ Sciatica	_____ Diabetes

Occupation: ___________________________________ Do you live alone: _____ Yes _____ No

Do you smoke cigarettes: _____ No _____ Yes If so, how many packs a day? ____

Do you drink _____ No _____ Yes If so, how many drinks per week? _____

Are you or planning on becoming pregnant? _____ No _____ Yes ***If so, THC is contraindicated for pregnant women and nursing mothers***

Past Medical History – Continued

_____ Weight Loss/Gain (lbs___) reason: __________	_____ Heart Disease – Specify: __________________
_____ Chronic Pain – specify: ____________________	_____ Circulation problems (stroke, phlebitis, etc.)
_____ Fibromyalgia	_____ Lung Disease – Specify: ___________________
_____ Migraine	_____ Asthma
_____ PTSD	_____ Shortness of Breath
_____ Anxiety	_____ COPD
_____ Depression	_____ Cancer – Specify: ________________________
_____ Bipolar	_____ Breast Lesions
_____ Schizophrenia	_____ Liver Disease – Specify: ___________________
_____ Kidney/Bladder Disease – Specify: __________	_____ Hepatitis A/B/C – Specify: _____________ ____
_____ Insomnia	_____ Glaucoma/Vision Problems – Specify ________
_____ Sleep Apnia	_____ MS/ALS
_____ Endocrine Problems – Specify: _____________	_____ Parkinson's Disease
_____ Rheumatic Disease - Specify: ______________	_____ Distonia

Surgical History: Please list any surgeries and date of such surgery: _____ None

Date of Surgery	Type of Surgery or Condition

Note non-surgical treatments received/receiving for the condition(s) for which you seek medical cannabis:

_____ Physical Therapy	_____ Pain Specialist	_____ Orthopedist
_____ Oncologist	_____ Injections	_____ Psychologist
_____ Heart Specialist	_____ Endocrinologist	_____ Chiropractor
_____ Social Worker	_____ Neurologist	_____ Acupuncture
_____ Psychiatrist	_____ Other – Specify: _________	

Activities of Daily Living Assessment: Please check if any of the following activities are substantially limited (i.e., pain/weakness/impaired strength or ability) by the medical conditions for which you seek a medical cannabis recommendation:

_____ caring for myself	_____ hearing	_____ walking
_____ bending	_____ learning	_____ thinking
_____ social interaction	_____ performing manual tasks	_____ eating
_____ standing	_____ speaking	_____ reading
_____ communicating	_____ operation of bodily function	_____ seeing
_____ sleeping	_____ lifting	_____ breating
_____ concentrating	_____ working	_____ other – Specify: __________

GOALS: Please detail what you hope to have as an outcome by using medical cannabis: ______________________

____

Medications: List all medications that you are currently taking:

Medication	Dosage	Times Per Day	Reason For Taking

List any medications to which you are allergic:

Medication	Type of Reaction

Supplements and Vitamins: List all supplements and vitamins that you are currently taking (include CBD)

Supplement/Vitamin	Dosage	Times Per Day	Reason For Taking