Patient History Form

Patient Information

Patient Name:

Drivers License Number:

Date of Birth:

Primary Phone Number:

Address:

Email Address:

City/State/Zip Code:

Sex: Male ☐ Female ☐

Patient History

Please check all the reasons for your visit today:

- ☐ HIV/AIDS
- ☐ Nausea
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Glaucoma
- ☐ Insomnia
- ☐ Depression
- ☐ Arthritis
- ☐ Migraine headaches
- ☐ Palpitations
- ☐ Muscle spasm
- ☐ Sever disability
- ☐ Seizures
- ☐ Anxiety
- ☐ ADHD
- ☐ Bipolar disorder
- ☐ Headaches

Please check all the symptoms that you have experience in the past year:

- [ ] Bleed or bruise easily
- [ ] Chronic Cough
- [ ] Coughing blood
- [ ] Dizziness
- [ ] Heartburn
- [ ] Constipation
- [ ] Blood in Stool
- [ ] Diarrhea
- [ ] Blood in Urine
- [ ] Pain while Urinating
- [ ] Increased Urination
- [ ] Skin Rashes
- [ ] Vision or eye problems
- [ ] Substance abuse
- [ ] Stomach pain
- [ ] Swollen ankles
- [ ] Arthritis
- [ ] Muscle spasms
- [ ] Asthma
- [ ] Alcoholism
- [ ] Hepatitis
- [ ] Tuberculosis
- [ ] Stroke
- [ ] Diabetes
- [ ] Other

- [ ] Schizophrenia
- [ ] Multiple Sclerosis
- [ ] Fever
- [ ] Joint Pain
- [ ] Toothache
- [ ] Chest Pain
- [ ] Depression
- [ ] Loss of Hearing/Ear ache
- [ ] Headaches
- [ ] Anorexia/Loss of appetite
- [ ] Nausea/Vomiting
- [ ] Difficulty swallowing
- [ ] Insomnia
- [ ] Anxiety/Nervousness
- [ ] Seizures (Epilepsy)
- [ ] High blood pressure
- [ ] Numbness in limbs
- [ ] AIDS/HIV
- [ ] Migraine headache
- [ ] Glaucoma
- [ ] Chronic Pain
- [ ] Cancer
- [ ] Kidney Disease
- [ ] Cachexia (Wasting Syndrome)
- [ ] Sinusitis

_____

Which best describes how these symptoms collectively interfere with your life? (Rate on a scale from 1-10, 1 being not at all and 10 being completely.)

Work:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10
Mood:	1	2	3	4	5	6	7	8	9	10
Relationship:	1	2	3	4	5	6	7	8	9	10
Physical Activity:	1	2	3	4	5	6	7	8	9	10

Other Complaints:

Medications And Allergies

Are you taking, or have you taken, any prescription medication(s)?

☐ YES ☐ NO

Are/were other prescriptions helpful?

☐ YES ☐ NO

Are you still taking other prescriptions?

☐ YES ☐ NO

Current Medications:

Allergies:

Social History

Have you ever been diagnosed with any of the following?

- ☐ ADD
- ☐ ADHD
- ☐ Physical Abuse
- ☐ Behavior issues
- ☐ School problems
- ☐ Sexual abuse
- ☐ Depression
- ☐ Emotional abuse

If you were diagnosed with any of the above, did you take any medications?

☐ YES ☐ NO

If so, what medications did you take?

Please list all major surgeries that required an overnight hospitalization with approximate dates:

Current and previous treatments:

- [ ] Yoga
- [ ] Chiropractor
- [ ] Acupuncturist
- [ ] Medications
- [ ] Stretching
- [ ] Vitamins
- [ ] Exercise
- [ ] Counseling
- [ ] Massage Therapy
- [ ] Physical Therapy
- [ ] Injections
- [ ] Other:

What has helped best with your illness?

_____

Are you currently on Parole or Probation?

- [ ] YES
- [ ] NO

With whom do you live with?

_____

If you are under the age of 21 and live with your parents, have you spoken to them about your medical cannabis use?

- [ ] YES
- [ ] NO

What do you do for exercise?

- [ ] Walk
- [ ] Run
- [ ] Bike
- [ ] Gym
- [ ] Swim
- [ ] Play Sport
- [ ] Other

_____

How many times a week do you exercise?

1 2 3 4 5 6 7

Do you smoke tobacco?

☐ YES ☐ NO

If so, how much tobacco do you smoke per day?

_____

Do you drink alcohol?

☐ YES ☐ NO

If so, how many drinks do you per day?

_____

Have you ever been arrested for the sale or possession of a controlled substance?

☐ YES ☐ NO

Are you currently or have you used any of the following drugs?

Cocaine Amphetamines Opiates LSD Ecstasy Downers/Pills Mushrooms Ketamine/GHB

☐ YES ☐ NO

Family History

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Domestic Partnership

Do you have children?

☐ YES ☐ NO

Are you currently pregnant?

☐ YES ☐ NO

In your family has there been a history of:

☐ Heart Disease
☐ Arthritis
☐ High Blood Pressure
☐ Depression
☐ Cancer
☐ Alcohol Abuse
☐ Drug Abuse
☐ Diabetes

Employment History

Are you currently employed?

☐ YES ☐ NO

What is your occupation?

_____

If you are not employed, what is your status?

☐ Unemployed
☐ Retired
☐ Disabled
☐ Workers Compensation
☐ Student
☐ Other

Physician Information

If another physician referred you please put their name here:

_____

Who is your primary care physician?

_____

Have you discussed medical cannabis with your primary care physician?

☐ YES ☐ NO

When was the last time you visited a physician?

☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months ☐ 7 Months
☐ 8 Months ☐ 9 Months ☐ 10 Months ☐ 11 Months ☐ 12 Months ☐ More than a year

Medical Cannabis Questions

Do you currently use cannabis, or have you in the past?

☐ YES ☐ NO

If your answer to the above question is NO, please skip this section.

Has medical cannabis helped to relieve your symptoms?

☐ YES ☐ NO

If so, what methods did you use to consume cannabis?

☐ Inhaling
☐ Orally with edibles or tinctures
☐ Topically with ointments or oils

How much cannabis would you estimate you use per week?

_____

How long have you used cannabis?

_____

Do you know how cannabis affects you?

☐ YES ☐ NO

Have you ever had a prescription for Marinol or Sativex?

☐ YES ☐ NO

When do you tend to medicate?

☐ Morning
☐ Afternoon
☐ Evening
☐ Throughout the day
☐ Do not currently medicate

Has the amount of cannabis needed to control your symptoms changed over time?

☐ YES ☐ NO

If it has changed, what do you attribute the change to?

_____

Have you ever stopped using cannabis and had your symptoms return or worsen?

☐ YES ☐ NO

Do you plan to use cannabis for?

☐ Pain Relief
☐ Assistance with sleeping
☐ Relieve loss of appetite
☐ Relieve nausea or vomiting:

Patient Signature

☐ "I hereby certify that the above information regarding my medical history and condition is true and correct to the best of my knowledge."

_____

Patient signature

_____ _____