

Date _____

New Patient History

Name _____

Age _____ Date of birth _____

Address _____ City _____ State _____ Zip _____

Phone _____ e-mail _____

Are you currently in school? Yes / No ___Full-time ___part-time If under 21 Living at home Yes/No
Highest year of school completed _____

Are you currently working? Yes / No ___Full-time ___part-time

What is /was your
job? _____

Military Service Yes / No Wartime service? Yes / No Which? _____

Do you currently have medical insurance? Yes / No

If yes, is it ___Medicare ___MediCal ___ your own private insurance or from an employer

Name, address, and **date last seen** by physicians (chiropractor, acupuncturist) who take care of you

Describe your medical problems, both physical and mental, for which you use, or would like to use, cannabis/medical marijuana , include when the problem began and any diagnosis you've received

OVER

Is the problem for which you use cannabis due to an injury or trauma? Yes / No
__Auto, other __Assault __War __Work __Sports __Surgery __Childhood
In what year did it occur _____

Check treatments that you have tried in treating your problem: medications
 surgery therapeutic injections physical therapy osteopathic care
 chiropractic acupuncture homeopathy counseling other _____

What has been most helpful _____

Check the most important reasons you use, or want to use, cannabis:

Relieve __ pain __cramps __muscle spasms __headaches __nausea/vomiting
__stress __anxiety __panic attacks __depression __itching

Improve __sleep __appetite __relax __concentration / focus __energy

Prevent __seizures __medication side effects __anger

Substitute for __alcohol __prescription medications

Are you **pregnant** now? Yes / No Are you currently **breast-feeding**? Yes / No

Do you now or have you ever had problems with (check box and circle choice)

- | | |
|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease (renal failure) |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Liver Disease (cirrhosis, hepatitis) |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Lung Disease (asthma) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Disorders (depression, anxiety, ADD, other) |
| <input type="checkbox"/> Intestinal Disorders (ulcers, IBS) | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Disorders (insomnia, sleep apnea) |
| <input type="checkbox"/> Substance Abuse (alcohol, other drugs) | <input type="checkbox"/> Weight loss |

List all **surgeries** you have had. Give dates.

List all **prescription medicines you are taking now**, and how often you take these

Do you currently or have you ever used:

Tobacco Yes/ No # cigarettes/day _____ Current _____ Past _____
Alcohol Yes/ No # of drinks/ week _____ Current _____ Past _____

OVER

Have you ever had a problem with ___Alcohol ___Opiates or Heroin ___Cocaine
___Methamphetamines ___Other ?

Have you ever or attended a drug or alcohol treatment program? Yes/ No

Does cannabis help you to not use the drugs or alcohol that you had a problem with? Yes / No

Legal History

Are you on probation or parole? Yes / No If yes, is it drug-related? Yes / No

Do you have a pending cannabis case? Yes / No

Do you have ANY pending legal case – including divorce or custody battle?_Yes/No

Are you currently using cannabis for your problem? If no, then ski to next page

Cannabis Use Pattern

Do you use cannabis? ___every day or almost every day ___2-3 time /week ___2-3 times/mos

On the days you use cannabis, how many times / day do you use? ___1-2 ___ 2-3 ___more than 3

Do you usually use cannabis ___ morning ___ afternoon ___ evening ___before sleep
___ middle of the night ___all day ___only after work ___depends on your symptoms

How many years (or months) approximately have you been using cannabis in this way? _____

Your primary method of administration Vapor Smoke Ingested Topical

Check any side effects or problems you are having from your use of cannabis:

___mental slowness ___tiredness ___problems with memory ___confusion
___uncoordinated movement ___loss of motivation ___nervousness ___fast heart beat
___dizziness ___cough ___difficulty concentrating ___paranoia
___problem using more than you'd like ___withdrawal symptoms when stop

Additional Information

Please provide any other information you believe is relevant to the doctor's evaluation

Patient Signature

STOP

Medical Marijuana Acknowledgement of Disclosure and Informed Consent

Read each item below and place your signature to indicate that you understand and agree to each item. Do not sign this agreement and do not use medical marijuana if you have questions about or do not understand the information you have received.

I _____ (Patient Name) understand that **the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that would very likely impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities.**

Smoking marijuana can cause respiratory harm, such as chronic bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer), and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth and tongue. I have been advised that cannabis smoke contains chemicals known as tars that may be harmful to my health. Vaporizers may substantially reduce many of the potentially harmful smoke toxins that are normally present in marijuana smoke.

I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include, but are not limited to:

- Unpleasant change in mood/sensation
- Fatigue
- Mental slowness
- Confusion
- Nervousness
- Dizziness
- Cough
- Problem with memory or concentration
- Loss of motivation
- Palpitations / fast heart beat
- Dependence or Addiction
- Impairment of motor skills, reaction time and physical coordination
- Difficulty in completing complex tasks
- Irritability

Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include but are not limited to nausea, vomiting, disturbances to heart rhythm.

For some patients, chronic marijuana can lead to laryngitis, bronchitis and general apathy.

I understand that some patients can become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.

I understand that some users develop a tolerance to marijuana. This means higher and higher doses are required to achieve the same symptom relief. I will notify my physician if I think I may be developing a tolerance to marijuana.

The possibility exists that marijuana may exacerbate schizophrenia in persons predisposed to that disorder.

I understand that using marijuana while under the influence of alcohol is not recommended.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities or contaminants.

OVER

Medical Marijuana Patient Agreement

I agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide or had any other mental problems. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of these problems.

I understand that the attending physician does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.

If I start taking medical marijuana, I agree to tell my attending physician if I:

- Start to feel sad or have crying spells
- Lose my appetite
- Become unusually tired
- Lose interest in my usual activities
- Have changes in my normal sleep patterns
- Become more irritable than usual
- Withdraw from family and friends

Should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use. I agree to discontinue its use and report any such problems or effects to the attending physician.

I understand that the physician is not providing, dispensing, or encouraging me to obtain medical marijuana.

I have attempted to obtain medical records pertaining to my condition or currently have no medical records pertaining to my condition. I have a primary care provider that helps guide the decisions I make with regard to my healthcare or currently choose to be under self-care only.

Release of Liability

The physician is addressing specific aspects of my medical care and, unless otherwise stated, is in no way establishing themselves as my primary care provider. The physician is only rendering an opinion regarding the therapeutic value of the use of medical marijuana. Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician and his/her principles, agents and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals in a result of my cannabis use.

I certify that I have read this document and declare under penalty of perjury that the information contained herein is true correct and complete

Patient Signature _____ Date _____