Print Form

CANNAMED

Patient Information

Name: _____ Date: _____

Age: _____ Gender: ☐ Male ☐ Female Date of Birth: _____

Address: _____

City: _____ State: AL ZIP: _____

Phone: _____ State Drivers Licence or ID # _____

Email: _____

How did you hear about CannaMed?

☐ Google ☐ News Paper ☐ Yahoo ☐ Craigslist ☐ Friend Other _____

Have you had a medical marijuana recommendation from a doctor before? ☐ Yes ☐ No

Your primary care physician information

Name: _____

Address: _____

City: _____ State: AL ZIP: _____

Phone: _____ Fax: _____

Past Medical History

Please list any medical condition that you have ever been evaluated by a physician, admitted to a hospital or are currently being treated for: (For example: HIV/Aids, Arthritis, Cancer, Glaucoma, Migraine Headaches, Weight Loss/Anorexia, Muscle Spasms, Seizures, Severe Nausea, High Blood Pressure, Depression, Anxiety, Heartburn, Irritable Bowel, Chronic Bronchitis, Asthma, Chronic Allergies, or any other disease affecting the kidneys, liver, nervous system, bladder, etc.)

Past Surgical History

Please list any surgeries that you have had in the past. Include the reason, date, hospital and doctor who performed the surgery

Are you allergic to any medications? ☐ Yes ☐ No

If you answered Yes to the question above please list the meds you are allergic to.

Current Medications

Please select the medications that you're currently taking on a daily or occasional basis (please include over the counter medications such as Claritin): Include the dosage and frequency of use.

- ☐ Acetaminophen
- ☐ Ambien
- ☐ Amitriptline
- ☐ Aspririn
- ☐ Atarax
- ☐ Baclofen
- ☐ Benadryl
- ☐ Bupropion
- ☐ BuSpar
- ☐ Cannabinoids
- ☐ Capsaicin
- ☐ Carbamazepine
- ☐ Celebrex
- ☐ Clonazepam
- ☐ Codeine
- ☐ Cymbalta
- ☐ Dalmane
- ☐ Darvocet
- ☐ Darvon
- ☐ Depakote
- ☐ Desipramine
- ☐ Dexamethasone
- ☐ Diazepam
- ☐ Diclofenac
- ☐ Diflunisal
- ☐ Dilantin
- ☐ Doxepin
- ☐ Duloxetine
- ☐ Effexor
- ☐ Elavil
- ☐ Etodolac
- ☐ Fenoprofen
- ☐ Fentanyl
- ☐ Flecainide
- ☐ Flexeril
- ☐ Fluoxetine
- ☐ Flurbiprofen
- ☐ Forte
- ☐ Gabapentin
- ☐ Halcion
- ☐ Hydrocodone
- ☐ Hydromorphone
- ☐ Hydroxyzine
- ☐ Ibuprofen
- ☐ Imipramine
- ☐ Indocin
- ☐ Indomethacin
- ☐ Ketoprofen
- ☐ Ketorplac
- ☐ Lamictal
- ☐ Lamotrigine
- ☐ Levorphanol
- ☐ Lidocaine
- ☐ Lyrica
- ☐ Meclofenamate
- ☐ Mefenamic acid
- ☐ Meperidine
- ☐ Methadone
- ☐ Mexiletine
- ☐ Morphine
- ☐ MS-Contin
- ☐ Nabumetone
- ☐ Naprosyn
- ☐ Naproxen
- ☐ Neurontin
- ☐ Norflex
- ☐ Norpramin
- ☐ Nortriptyline
- ☐ Oramorph SR
- ☐ Oxaprozin
- ☐ Oxycodone
- ☐ Oxicontin
- ☐ Oxymophone
- ☐ Pamlor
- ☐ Parafon
- ☐ Paroxetine
- ☐ Paxil
- ☐ Percocet
- ☐ Phenytoin
- ☐ Piroxicam
- ☐ Prednisone
- ☐ Pregablin
- ☐ Propoxyphene
- ☐ Prozac
- ☐ Robaxin
- ☐ Roxicodone
- ☐ Salsalate
- ☐ Sinequan
- ☐ Soma
- ☐ Sulindac
- ☐ Tegretol
- ☐ Tofranil
- ☐ Tolmetin
- ☐ Topamax
- ☐ Topiramate
- ☐ Tramadol
- ☐ Trilisate
- ☐ Tylenol #3
- ☐ Tylenol #4
- ☐ Ultram
- ☐ Valium
- ☐ Valproic acid
- ☐ Venlafaxine
- ☐ Vicodine
- ☐ Vioxx
- ☐ Vistaril
- ☐ Wellbutrin
- ☐ Xanax
- ☐ Zoloft

Others: _____

Do you smoke cigarettes? ☐ Yes ☐ No

If yes to the question above how much do you smoke? less than 1/2 a pack a day.

Review of Symptoms

GENURAL
- ☐ Dizziness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Poor energy

GASTROINTESTINAL
- ☐ Abdominal pain or cramps
- ☐ Poor Appetite
- ☐ Bowel Changes
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Arthritis
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders
- ☐ Muscle Cramps

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Disturbing feelings
- ☐ Panic attacks
- ☐ Restlessness

CARIOVASCULAR
- ☐ Cardiac palpitations
- ☐ High blood pressure
- ☐ Rapid heart beet
- ☐ Irregular heart beat

NEUROLOGICAL
- ☐ Fainting
- ☐ Headache
- ☐ Numbness
- ☐ Seizures

Conditions
- ☐ Aids
- ☐ Aicoholism
- ☐ Arthritis
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ HIV Positive
- ☐ Migraine Headaches
- ☐ Crohn's Disease
- ☐ multiple sclerosis
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Anorexia
- ☐ Glaucoma
- ☐ Insomnia
- ☐ Depression
- ☐ Stress Disorder

Others: _____

Chief Complaint

Please describe the medical condition or complaint that you are seeking a recommendation for medical marijuana: (please include when you first noticed the symptoms and when you received the diagnosis)

Does this medical condition limit your ability to conduct major life activities? (Work, Eat, Sleep, Interact with others) Please describe:

Do you feel that if this medical condition is not alleviated, that it could cause serious harm to your safety, physical or mental health? ☐Yes ☐No

Have you received medical care or been evaluated by a physician for this medical condition? ☐Yes ☐No

If yes, please provide the **name, address** and **date last seen** by the physician (including chiropractor/ acupuncturist) that diagnosed and/or treated you for this medical condition.

If not listed above, please describe all treatments that you have received to date for your current medical problems such as the **medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, chiropractic care or other:**

Cannabis (MARIJUANA) History

Do you currently use cannabis to treat your current medical condition? ☐Yes ☐No

At what age did you discover that Cannabis eased your medical symptoms? _____

Does cannabis provide relief for your symptoms? (if yes please describe. For example, less pain or nausea)

How often do you use marijuana: ☐ Daily ☐ Weekly ☐ Monthly

How much cannabis do you consume per treatment? 1/8 gram

What method do you currently use to consume the cannabis? ☐ Vaporize ☐ Ingest ☐ Smoke ☐ anointing oil

Legal History

Are you currently on probation or parole? ☐ Yes ☐ No

Do you have a pending cannabis case? ☐ Yes ☐ No

Additional Information

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

Are you now or were ever employed by any City, State or Federal Government Agency or Department?

☐ Yes ☐ No

If you answered yes to the question above please explain:

I understand that the Physician may be contacted to verify and/or authorize my status as their patient as well as any prescription and/or recommendation that may or may not be issued by them. By signing below, I hereby authorize the physician and / or CannaMed to make such verifications or authorization. My signature below shall serve as a release for this purpose only and shall not serve as a waiver of my other patient and physician privacy rights as detailed under California State Laws and Federal HIPAA regulations.

I understand if the physician requests medical records, follow up appointments , prescription medications or any thing else pertaining to my medical marijuana recommendation, my recommendation will become null and void if the request is not fulfilled with in thirty (30) days.

Patient Signature _____ Date ___/___/___