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PATIENT QUESTIONNAIRE

A patient coordinator will assist you with all your forms and arrange your Dr. appointment

Patient Address:

PATIENT INFORMATION		
FIRST Name:	**LAST Name:**	**Date of Birth:**
Height:	Weight:	Gender :
Home Phone:	Cell Phone:	Work Phone:
Email Address:	SKYPE :	

MEDICAL HISTORY

List the medical condition(s)/problem(s) for which you use or would like to use medical cannabis:

List all of your medications including dosage: **List any medications you are allergic to:**

Do you use marijuana to reduce or eliminate the use of any medications that have been Prescribed for your medical condition? ( ) Yes ( )No
If yes, which medication(s) have you reduced or eliminated and why? Please include dosage details.

How often do you use marijuana?
( ) Everyday ( ) Every other day ( ) 1-2 times per week ( ) more than once a month ( )Other
What is your preferred method of using marijuana?
( )Smoking ( )Vaporizing ( ) Ingesting ( )Topical
Patient has been informed of possible side effects that may occur from use of marijuana (X) _____

How much marijuana do you currently use per day, measured in grams:
How effective is marijuana for your medical condition?
( )Very effective ( )Effective ( )Only somewhat effective
Have you ever experienced an unpleasant /unwanted side effects of marijuana? ( )Yes (X)No

Have you been evaluated by another physician for medical marijuana? ( ) Yes ( ) No
If yes, when were you evaluated? Name of the physician that evaluated you?

Do you have or have you ever had any of the following medical conditions:
( ) Asthma/Lung Disease ( )Hepatitis ( ) Stroke ( ) Kidney Disease ( ) Thyroid ( ) Heart Disease ( ) Cancer
( ) ADD/ ADHD ( ) Substance Abuse ( ) Depression ( ) MS ( ) Schizophrenia ( ) Hyper Tension

List the name, last date seen and type of health care provider (doctor, chiropractor, therapist, psychologist,

List all prior surgeries:

Do you currently use: Tobacco( ) Yes ( ) No per day( ) **Alcohol** ( ) Yes( ) No - per week ( )

Patient Signature: _____ Date: _____