Eastern Shore MediCann Clinic, LLC

New Patient Medical History and Intake Form
Medical Marijuana Certification

Name_____ Date of Birth_____

Social Security Number_____ Gender: ▫ Male ▫ Female

Address: Street: _____

City: _____ State_____ Zip Code_____

E-mail:_____

Home Phone: _____ Cell Phone: _____

Mother's Maiden Name: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____

Address: Street: _____

City: _____ State_____ Zip Code_____

Phone: _____

Primary medical condition for which Medical Marijuana is requested: ▫Cachexia ▫Anorexia ▫Wasting Syndrome ▫Severe pain ▫Severe Nausea ▫Seizures ▫Severe or persistent muscle spasms ▫Glaucoma ▫Post traumatic stress disorder (PTSD) ▫Chronic pain

Please describe when this condition started: _____

Other Medical Problems and/or Symptoms

1. _____
2. _____
3. _____

Please describe any previous tests (X-rays, CT scan, MRI, EMG etc) or treatments (Surgery, Injections, Medications and Therapy etc) you have had for the treatment of this/these conditions:

_____

_____

_____

Please describe what makes the symptoms worse: ▫sitting ▫standing ▫rest ▫heat ▫cold ▫walking ▫exercise ▫other

Please describe what makes the symptoms better: ▫sitting ▫standing ▫rest ▫heat ▫cold ▫walking ▫exercise ▫other

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Past Medical History: *Please note if you have had any of the following Medical Problems*

▫Arthritis ▫Anxiety ▫Chronic Pain ▫Depression
▫Diabetes ▫Head Injury ▫Heart Disease ▫High Blood Pressure
▫Hepatitis C ▫Hyperthyroid ▫Kidney Disease ▫Liver Disease
▫Multiple Sclerosis ▫Osteoporosis ▫Seizures ▫Sleep Apnea
▫Stroke ▫Ulcers ▫Gout ▫Lupus
▫Rheumatoid Arthritis ▫Other _____

Surgical History: *Please note if you had any surgeries and write date of each surgery*

▫None ▫Surgery _____ Date: _____

Are you pregnant? ▫Yes ▫No ▫Unsure Date of last menstrual period: _____

Allergies: ▫None Medication allergy: _____ Food_____

Family History: *Please write if anyone in your immediate family has any of the following illnesses:*

▫None/don't know ▫Alcoholism ▫Arthritis ▫Depression ▫*Cancer*
▫Multiple Sclerosis ▫Drug Use ▫*Diabetes* ▫Bipolar disorder ▫Heart Disease
▫Parkinsonism ▫*Rheumatoid Arthritis* ▫*Lupus* ▫Gout ▫Other_____

Medications: Please list ALL medications/herbs you are taking. Use back of this page if needed.

Medications/Supplements	Dosage	How long have you been taking this medication?

Functional History: How do your symptoms affect your daily activities?_____

_____

Do you use any assisted devices? ▫No ▫Cane ▫Walker ▫Crutches ▫Wheelchair

Other comments or concerns you wish to address with the physician?_____

_____

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Review of Systems Checklist: (please check all that apply to your current condition)

General
- ▫ Weight loss or gain
- ▫ Fatigue
- ▫ Fever or chills
- ▫ Weakness
- ▫ Trouble sleeping

Head
- ▫ Headache
- ▫ Head injury
- ▫ Neck pain

Eyes
- ▫ Vision loss/changes
- ▫ Glasses or Cataracts
- ▫ Pain
- ▫ Redness
- ▫ Flashing lights
- ▫ Glaucoma
- ▫ Cataracts

Nose
- ▫ Stuffiness
- ▫ Discharge
- ▫ Itching
- ▫ Hay fever
- ▫ Nosebleeds
- ▫ Sinus pain

Respiratory
- ▫ Cough
- ▫ Sputum
- ▫ Coughing up blood
- ▫ Shortness of breath
- ▫ Wheezing
- ▫ Painful breathing

Urinary
- ▫ Urgency
- ▫ Burning or pain
- ▫ Blood in urine
- ▫ Change in urinary strength

Throat
- ▫ Bleeding
- ▫ Dentures
- ▫ Sore tongue
- ▫ Dry mouth
- ▫ Sore throat
- ▫ Hoarseness
- ▫ Thrush
- ▫ Non-healing sores

Cardiovascular
- ▫ Chest pain or discomfort
- ▫ Tightness
- ▫ Palpitations
- ▫ Shortness of breath with activity
- ▫ Difficulty breathing lying down
- ▫ Swelling
- ▫ Sudden awakening from sleep with shortness of breath

Vascular
- ▫ Calf pain with walking
- ▫ Leg cramping

Musculoskeletal-
- ▫ Muscle or joint pain
- ▫ Stiffness
- ▫ Back pain
- ▫ Redness of joints
- ▫ Swelling of joints
- ▫ Trauma

Neck
- ▫ Lumps
- ▫ Swollen glands
- ▫ Pain
- ▫ Stiffness

Gastrointestinal
- ▫ Swallowing difficulties
- ▫ Heartburn
- ▫ Change in appetite
- ▫ Nausea
- ▫ Change in bowel habits
- ▫ Rectal bleeding
- ▫ Constipation
- ▫ Diarrhea
- ▫Yellow eyes or skin

Neurologic
- ▫ Dizziness
- ▫ Fainting
- ▫ Seizures
- ▫ Weakness
- ▫ Numbness
- ▫ Tingling
- ▫ Tremor

Breasts
- ▫ Lumps
- ▫ Pain
- ▫ Discharge
- ▫ Self-exams
- ▫ Breast-feeding

Hematologic
- ▫ Ease of bruising
- ▫ Ease of bleeding

Endocrine
- ▫ Head or cold intolerance
- ▫ Sweating
- ▫ Frequent urination

Psychiatric
- ▫Nervousness
- ▫Depression
- ▫PTSD

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Social History: Are you currently employed ? ▫Yes ▫No What type of work _____

If you are no longer working why did you stop and do you expect to return to work? _____
_____

Are you on disability? (start date)_____ On workmen's compensation?(start date) _____

Are you? ▫Married ▫Single ▫Divorced ▫Widowed/Widower
Smoking History: ▫ no ▫ ex-smoker ▫ current
Drinking History: ▫no ▫ ex-drinker ▫ current
Drug Use: ▫no ▫current ▫past ▫cocaine ▫marijuana ▫heroin ▫Other
Have you ever been addicted to prescription drugs ▫ Yes ▫ No

Psychiatric History: ▫ no Have you ever seen a ▫ psychiatrist ▫ psychologist ▫ social worker

Cannabis History: Are you currently using marijuana? ▫ Yes ▫ No
When did you start? Frequency of Use : ▫ daily ▫ weekly ▫ monthly

Delivery System: ▫ pipe ▫ joint ▫ vaporizer ▫ tincture ▫ food

Have you had any adverse effects from cannabis? ▫yes ▫ no
if yes , ▫ anxiety ▫ insomnia ▫ depression ▫ paranoia ▫ other_____ _____

Does cannabis provide relief from your medical symptoms/problem? ▫yes ▫ no

Pain Questionnaire:

Where is your worst pain?_____

How and when did your pain begin?_____

Does your pain radiate? To: ▫ R arm ▫L arm ▫R leg ▫L leg ▫other

Is the pain: ▫sharp ▫dull ▫burning ▫aching ▫stabbing ▫ shooting ▫throbbing
▫cramping ▫electric ▫intermittent ▫steady ▫superficial ▫deep Other_____

Please rate your pain on a scale of 0-10 with 0 being no pain and 10 the worst pain imaginable.

0------1-------2------3------4------5-------6-------7-------8-------9--------10

How long has your pain been at this level?_____

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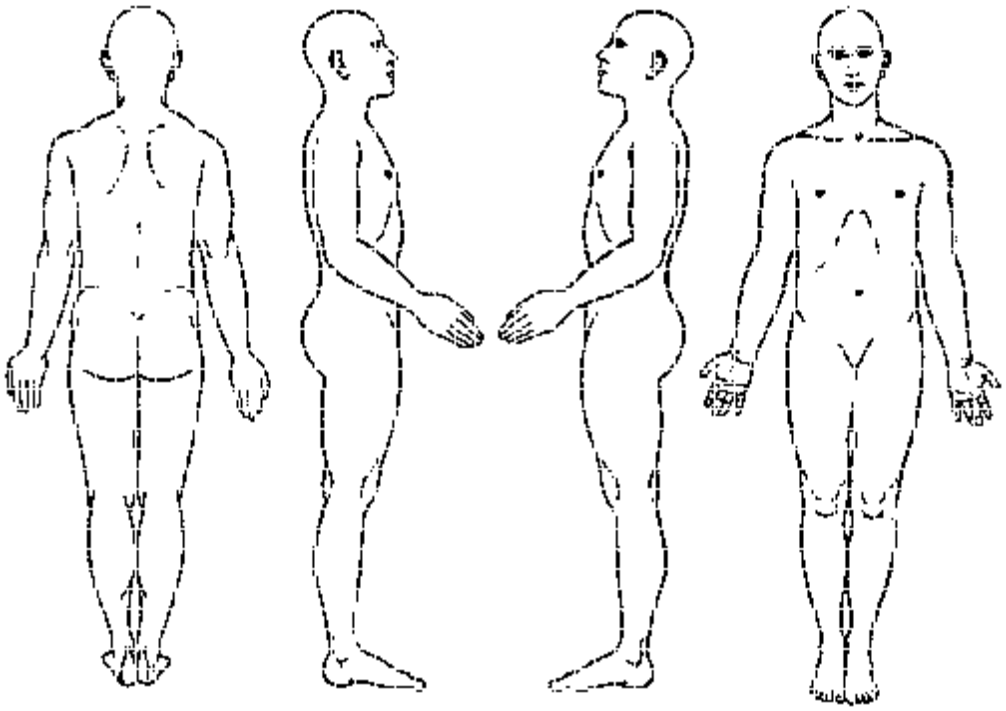
On diagram below please mark the areas where you have pain
Use the symbols to indicate where your pain is:
Moderate Pain = o Severe Pain = x Numbness = N Ache= A



L Back R **R Side** **L Side** **R Front L**

I believe that my physical and/or mental health will worsen, if I do not have medical marijuana available as self-medication. ▫ Agree ▫ Do not Agree

I consider my medical condition to be debilitating and that my condition is presently progressing to an extent that one or more major life activities (i.e., eating, sleeping, working, socializing) are substantially limited. ▫ Agree ▫ Do not Agree

My signature below attests to the fact that I have read and have accurately completed this form to the best of my knowledge. All information regarding my medical condition and the records I am submitting is completely truthful and represents the medical condition for which I am seeking treatment. I voluntarily consent to this evaluation and understand that I am solely responsible for payment for services.

Patient's Signature_____ **Date** _____