MedMar Medical LLC

New Patient Medical History and Intake Form
Medical Marijuana ("MMJ") 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 MMJ is requested:_____

Please describe when this condition started: _____

_____

Other Medical Problems and/or Symptoms

1. _____
2. _____
3. _____

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

_____

_____

_____

Please describe what makes the symptoms worse: □sitting □standing □rest □heat □cold □walking □exercise □sex □touch □other:_____

Please describe what makes the symptoms better: □sitting □standing □rest □heat

□cold □walking □exercise □sex □touch □other:_____

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

□ Arthritis	□ Anxiety Disorder	□ 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 have had any surgeries and write date of such surgery*

□ None □ Surgery _____ Date: _____

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

Allergies: □None known Medication allergy:_____ **Food**_____

Family History: Please write if anyone in your immediate family has any of these 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.

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

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

_____

Do you use any assistive devices? □no □cane □walker □crutches □wheelchair

Other comments or concerns you wish to address with the physician_____

_____

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

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

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

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

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

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

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

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

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

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

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

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

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

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 disabiilty? (start date) _____ On workmen's compensation?(start date)_____

Do you have any pending legal matters relating to your medical condition? □ yes □ no
Are you on parole or probation or have a pending cannabis legal problem: □ yes □ no

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? _____

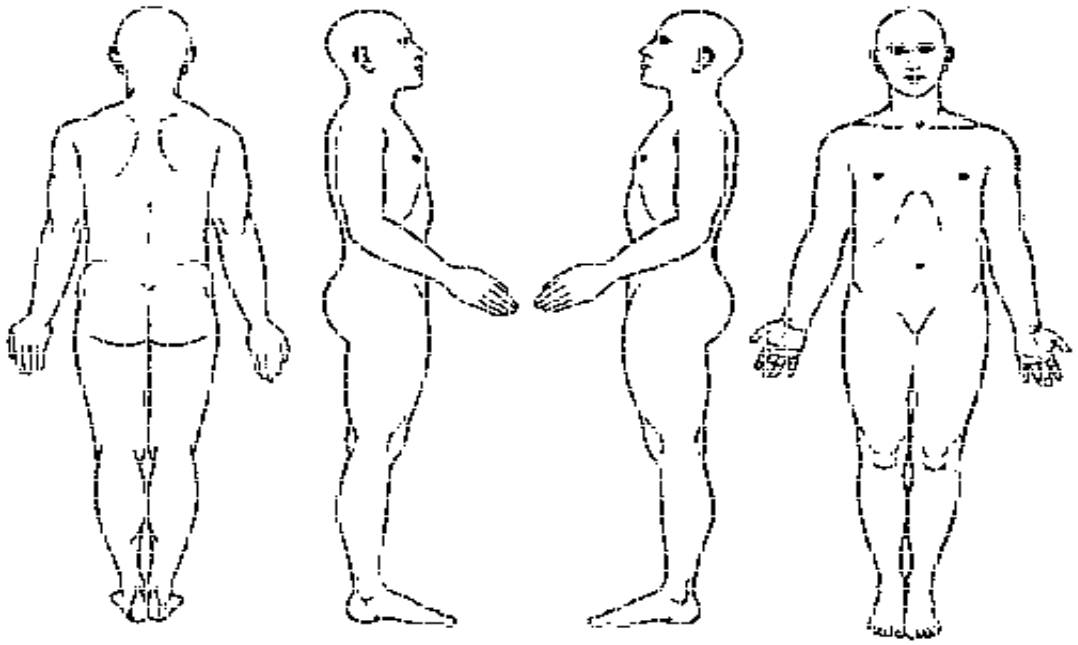
Does your pain radiate? To: □ R arm □L arm □R leg □L leg □other_____

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?_____

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**_____