Patient Medical History Form for Evaluation of Medical Cannabis

Patient's Name: _____ Date: _____

1. **Medical diagnosis**: Check one or more

____ Severe Pain _____ Chronic Pain ____ Severe Nausea _____ Anorexia

____ Cachexia ____ Wasting Syndrome ____ Post Traumatic Stress Disorder

____ Severe and persistent muscle spasms

____ Glaucoma ____ Seizure Disorder

2. **What treatments have you had for your condition(s) and what were the response?**

Medications Tried:

PT:

Injections:

Procedures/Surgeries:

Counseling:

Acupuncture:

Describe your conditions (include symptoms, location, radiation of symptoms, severity, what aggravates it, what helps it)):

Name: Date:

When did your condition begin? _____

Severity of symptoms?

Explain in detail how does it interfere with your activities (social, sleep, exercise, walking, stairs, work, appetite, mood)?

Past/Current Medical History

___ Number of alcoholic drinks per day: _____ per week: _____

___ History of opiate abuse? ____ Current opiate use?

___ History of chronic marijuana use? ____ Current tobacco use?

____ History of alcohol abuse? ____ History of drug addiction?

___ Coronary Heart Disease ____ Aortic Aneurysm

___ Stroke/TIA _____ Congestive Heart Failure

___ Peripheral Vascular Disease _____ COPD/Chronic Bronchitis/Emphysema

___ Asthma _____ Seizures

____ Atrial Fibrillation/Tachycardia _____ Cardiac Arrest

____ Depression (past or current) ____ Anxiety (past of current)

____ Bipolar Disorder ____ Psychosis/Hallucinations

____ Chronic Dizziness ____ Kidney or Liver disease

____ High blood pressure ____ Diabetes

____ Thyroid disease ____Eating disorders (current or in past)

____ Dry eyes or mouth ____ Dental problems

____ Possible pregnancy? Y/N When was last menstrual period? _____

____ Breast Feeding? Y/N _____ On a blood thinner

Name: Date:

Hospitalizations (include psychiatric/eating disorder/medical):

Other medical Conditions not listed above:

Past Surgeries:

Allergies to Medications:

Current Medications (include recreational drug use, prescription meds, herbs, vitamins, supplements):

Family History: (include history of drug addiction, alcohol abuse, psychiatric disorders, medical problems) :

Mother: Alive/Deceased; Age____

Father: Alive/Deceased; A ge ____

Siblings:

Name **Date:**

Social History:

Smoker? Y/N When quit? _____ ---- Amount Smoked _____ Packs/day

Alcohol Y/N Amount per week _____

Occupation: _____

Marital Status _____ single ____ divorced ____ married

Children ____ how many

Hobbies:

Pets: