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. **When did your condition begin**? _____
3. **Describe your condition(s)** (include symptoms, location, radiation, severity, what aggravates it, what helps it?

4. **Severity of symptoms**? Please rate on scale of 1 to 10 (10 being the worse)

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

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

-Medications Tried for you conditions and response (past and current**):**

-Physical therapy – When? _____ How long ? _____

Any relief with PT? Y/N/Some_____ block/rhizotomy)How many injections have you had for your pain condition? _____Who did your injections? Please circle - (Orthopedist/Physiatrist-Pain specialist/Anesthesiologist/Rheumatologist)

-List Procedures/Surgeries for your condition:

-Psychological Counseling related to your condition? Y/N For how long? _____

-Acupuncture/Massage/Meditation? How long, what was response?

Past/Current Medical History

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

___ History of opiate abuse? ____ Current opiate use? Y/N

___ 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

____ Headaches/Migraines ____Visual problems

____ Problems with Hearing ____Tinnitus or Vertigo

____ Chronic sinus problems ____ Dizziness or Syncope (loss of consciousness)

____ Chronic hoarseness ____ TMJ problems

____ Neck pain

____ Arthritis

____ GERD

____ Inflammatory Bowel Disease

____ Rheumatoid Arthritis

____ Kidney Stones

____ Incontinence of bowel/bladder

____ Chronic insomnia

____ Chronic Diarrhea

____ Blood in stool

____ Numbness/Tingling

____ Joint problems (pain/swelling)

____ chronic back pain

____ Irritable Bowel

____ Autoimmune Disease

____ Peripheral Vascular Disease/Claudication

____ BPH

____ Frequent Falls

____ Sleep Apnea/Restless legs

____ Chronic Constipation

____ History of cancer or current cancer

____ Weakness

All 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; Age ____

Siblings:

Social History:

Any current recreational drug use? Y/N

Use of sleep meds? Y/N Please list: _____

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:

Have you ever tried cannabis? Y/N If yes, what was the effect? (paranoi/anxiety/pain relief/better sleep/relaxation/decreased muscle spasms/etc).