IDENTIFYING DATA:

Last name: ____________________________ First name: __________________________ MI: _____________
Birth date: _____________________________ Age: _________ Gender: ❑ Male ❑ Female
SS#: ____________ - __________ - ___________ and/or Driver's License #: ___________________________
Address: ____ City: ______________ State: _____ Zip: ________
Home phone: ___________________ Work phone: __________________ Cell phone: __________________
Fax: ___________________________ Email: ____
Best time to contact: _________________________________ ❑anytime ❑morning ❑afternoon ❑evening
Race: ❑African ❑Asian ❑Hispanic ❑ Caucasian ❑ Native American ❑ Pacific Is. ❑Others________
Occupation(s): ____
Current employment: ❑Full Time ❑Part Time ❑Unemployed ❑Retired ❑Disabled

Emergency contact: *(Name, Relationship, Phone)* ____

DEMOGRAPHIC INFORMATION:

Birth order: Born ❑1st ❑2nd ❑3rd ❑4th ❑5th ❑6th ❑7th _____ Out of ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ____
Birthplace: ____
Years of education: ❑<10 ❑11 ❑12 ❑13 ❑14 ❑15❑16 ❑>16 Degree(s) obtained: ____________________
Major or Area of Specialty: ____
Occupation(s) / Other Training, Certifications: ____

Military: ❑Yes ❑No Branch of Service: ❑Army ❑Air Force ❑Marines ❑Navy ❑Coast Guard
Service in Viet Nam: ❑Yes ❑No Gulf War: ❑Yes ❑No Other: _________ Highest Rank: ____________
Length of Service: From ___ to ____ Discharge: ❑Honorable ❑Dishonorable ❑General ❑Medical ❑ others
Citations: ____

Marital status: ❑Single ❑Married ❑Partner ❑Widowed ❑Divorced ❑Separated
Spouse / partner's name: __________________________ Spouse / partner's occupation: _________________
Living Situation: ❑alone ❑with spouse ❑partner ❑with parent(s) ❑with children ❑with friend(s)
Domicile: ❑house ❑mobile home ❑apartment ❑institution ❑homeless ❑others _______
Household members: first name, age and relationship ____

GENERAL INFORMATION:

Do you have medical insurance? ❑Yes ❑No
If yes, Identify: ❑MediCal ❑Medicare ❑HMO ❑PPO ❑Kaiser ❑None ❑Others:__________
Primary care physician or clinic, Name: ______________________________Phone: _____________________
Address ____ City _________________ Zip ___________
Specialist / Consultant, Name and Location: ____
Specialist / Consultant, Name and Location: ____
Specialist / Consultant, Name and Location: ____
Do you receive a pension, insurance payment or compensation for illness or injury? ❑Yes ❑No

Are you a registered voter? ❑Yes ❑No
Have you named an agent to make health care decisions for you? ❑Yes ❑No
Have you put it in writing? ❑Yes ❑No

Name _______________________ Address ____________________________Phone ____________________

MEDICAL HISTORY

Chief Complaint(s):
What is the main problem for which you seek evaluation and treatment today (or the main reason you currently use cannabis) i.e. nausea, anorexia, spasms, pain, etc.? ____
____
____

When did this problem start?
❑< 1 month ❑< 1 year ❑1 – 3 years ❑3 – 5 years ❑5 – 10 years ❑> 10 years

When did you last see your doctor or a specialist about this complaint?
❑< 1 month ❑< 1 year ❑1 – 3 years ❑3 – 5 years ❑5 – 10 years ❑> 10 years

Trauma or Injury Questions:
Date of Injury / Illness: ____

Have you been injured in traffic accidents?	❑ Yes	❑ No	Date(s): _______________
Have you been injured in other accidents?	❑ Yes	❑ No	Date(s): _______________
Have you had any fractures or dislocations?	❑ Yes	❑ No	Date(s): _______________
Have you been injured in an assault or fight?	❑ Yes	❑ No	Date(s): _______________
Have you been injured after use of alcohol?	❑ Yes	❑ No	Date(s): _______________
Have you had a head injury?	❑ Yes	❑ No	Date(s): _______________

Check treatment modalities that you have tried in treating your problem:
❑ Medications ❑ Surgery ❑ Therapeutic injections ❑ Physical therapy ❑ Osteopathic Care
❑ Chiropractic Care ❑ Acupuncture ❑ Counseling ❑ Others: _______________

Current Prescription Medications: *List names, dosage, frequency of use, and how long taken*
1. ____________ Dosage ____________ Frequency ____________ Duration ____________
2. ____________ Dosage ____________ Frequency ____________ Duration ____________
3. ____________ Dosage ____________ Frequency ____________ Duration ____________

Previous Prescription Medications: *(relevant) names, duration, and reasons of stopping.*
1. ____________ ____________ ____________
2. ____________ ____________ ____________
3. ____________ ____________ ____________

Over-the-Counter and Herbal Medications: *List products that you use or have used in the past for the condition for which cannabis is used (intended), i.e. ibuprofen, aspirin, glucosamine, milk thistle.*
____
____

ALLERGIES:

Medication Intolerance:	❑ Yes	❑ No	Explain: _______________
Food Allergies:	❑ Yes	❑ No	Explain: _______________

OTHER DRUG USE:

Tobacco: ❑Yes ❑No	Cigarettes / day ________	Years of smoking ________	Quit date ________
Alcohol: ❑Yes ❑No	Drinks / day or week ________	Years of drinking ________	Quit date ________
Caffeine: ❑Yes ❑No	Cups / day [Coffee ___ Tea ___ Soda ___]	Years of drinking ________	Quit date ________
Opiates / Heroin:	________ times per month	Years of use ________	Quit date ________
Cocaine:	________ times per month	Years of use ________	Quit date ________
Amphetamines / Ecstasy	________ times per month	Years of use ________	Quit date ________
LSD / Psilocybin / Peyote:	________ times per month	Years of use ________	Quit date ________

PAIN MEDICATIONS REVIEW

Please ✓ the medication(s) that you have sampled in the past.

- ❑ Acetaminophen
- ❑ Ambien
- ❑ Amitriptyline
- ❑ Aspirin
- ❑ Atarax
- ❑ Baclofen
- ❑ Benadryl
- ❑ Bupropion
- ❑ BuSpar
- ❑ Cannabinoids
- ❑ Capsaicin
- ❑ Carbamazepine
- ❑ Celebrex
- ❑ Clonazepam
- ❑ Codeine
- ❑ Cymbalta
- ❑ Dalmane
- ❑ Darvocet
- ❑ Darvon
- ❑ Depakote
- ❑ Desipramine
- ❑ Dexamethasone
- ❑ Diazepam
- ❑ Diclofenac
- ❑ Diflunisal
- ❑ Dilantin
- ❑ Doxepin
- ❑ Duloxetine
- ❑ Effexor
- ❑ Elavil
- ❑ Etodolac
- ❑ Fenoprofen
- ❑ Fentanyl
- ❑ Flecainide
- ❑ Flexeril
- ❑ Fluoxetine
- ❑ Flurbiprofen
- ❑ Forte
- ❑ Gabapentin
- ❑ Halcion
- ❑ Hydrocodone
- ❑ Hydromorphone
- ❑ Hydroxyzine
- ❑ Ibuprofen
- ❑ Imipramine
- ❑ Indocin
- ❑ Indomethacin
- ❑ Ketoprofen
- ❑ Ketorolac
- ❑ Lamictal
- ❑ Lamotrigine
- ❑ Levorphanol
- ❑ Lidocaine
- ❑ Lyrica
- ❑ Meclofenamate
- ❑ Mefenamic acid
- ❑ Meperidine
- ❑ Methadone
- ❑ Mexiletine
- ❑ Morphine
- ❑ MS-Contin
- ❑ Nabumetone
- ❑ Naprosyn
- ❑ Naproxen
- ❑ Neurontin
- ❑ Norflex
- ❑ Norpramin
- ❑ Nortriptyline
- ❑ Oramorph SR
- ❑ Oxaprozin
- ❑ Oxycodone
- ❑ Oxycontin
- ❑ Oxymorphone
- ❑ Pamelor
- ❑ Parafon
- ❑ Paroxetine
- ❑ Paxil
- ❑ Percocet
- ❑ Phenytoin
- ❑ Piroxicam
- ❑ Prednisone
- ❑ Pregablin
- ❑ Propoxyphene
- ❑ Prozac
- ❑ Robaxin
- ❑ Roxicodone
- ❑ Salsalate
- ❑ Sinequan
- ❑ Soma
- ❑ Sulindac
- ❑ Tegretol
- ❑ Tofranil
- ❑ Tolmetin
- ❑ Topamax
- ❑ Topiramate
- ❑ Tramadol
- ❑ Trilisate
- ❑ Tylenol #3
- ❑ Tylenol #4
- ❑ Ultram
- ❑ Valium
- ❑ Valproic acid
- ❑ Venlafaxine
- ❑ Vicodin
- ❑ Vioxx
- ❑ Vistaril
- ❑ Wellbutrin
- ❑ Xanax
- ❑ Zoloft
- ❑ Others: __________

Marijuana as Medicine

Prior to the usage of cannabis, sampling other analgesics may be beneficial in managing pain. Although U.S. law classifies marijuana as a Schedule I controlled substance (which means it has no acceptable medical use), a number of patients claim that ***smoking pot*** *has helped them deal with pain or relieved the symptoms of glaucoma, the loss of appetite that accompanies AIDS, or nausea caused by cancer chemotherapy. There is, however, <u>no solid evidence that smoking marijuana creates any greater benefits than approved medications</u> (including oral THC) now used to treat these patients, relieve their suffering, or mitigate the side effects of their treatment. Anecdotal assertions of beneficial effects have yet to be confirmed by controlled scientific research.*

Some of the marijuana dangers include impaired perception; diminished short-term memory; loss of concentration and coordination; impaired judgment; increase risk of accidents; loss of motivation; diminished inhibitions; increased heart rate, anxiety, panic attacks, and paranoia; hallucinations; damage to the respiratory, reproductive, and immune systems; increase risk of cancer; and psychological dependency.

Initials _______

FAMILY MEDICAL HISTORY *(✓ check the box most applicable to you)*

Are you adopted? ❑Yes ❑No

	Alive Age	Deceased Age	Heart Disease	Hyper-tension	Stroke	Diabetes	Cancer	Substance Abuse	Mental Disorder	Arthritis	Other
Mother											
Father											
M Gmother											
M Gfather											
P Gmother											
P Gfather											

M Gmother: Maternal Grandmother; M Gfather: Materal Grandfather; P Gmother: Paternal Grandmother, P Gfather: Paternal Grandfather

Ages and health of brothers, sisters and children:

_______ ____________________________________ _______ ____________________________________
_______ ____________________________________ _______ ____________________________________
_______ ____________________________________ _______ ____________________________________

PAST MEDICAL HISTORY

(✓ check the box most applicable to you)

- ❑ Arthritis
- ❑ Back and neck pain
- ❑ Blood Disorders (anemia, abnormal clotting)
- ❑ Brain disorders (epilepsy, trauma, etc)
- ❑ Breast lesions
- ❑ Cancer, specify:
- ❑ Chronic pain, specify:
- ❑ Circulation (stroke, phlebitis, etc)
- ❑ Diabetes
- ❑ Dystonia (spasms, tremors, Parkinson's)
- ❑ Ear problems (tinnitus, hearing loss)
- ❑ Eating disorder (anorexia, bulimia)
- ❑ Endocrine problems (thyroid, hormones)
- ❑ Eye problems (glaucoma, cataracts)
- ❑ Genital / GYN problems
- ❑ Heart disease
- ❑ Herpes zoster / shingles / other
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Intestinal disorders (ulcers, colitis, IBS)
- ❑ Kidney disease (cystitis, renal failure)
- ❑ Liver disease (cirrhosis, hepatitis B or C)
- ❑ Lungs disease (asthma, emphysema)
- ❑ Mental disorders (depression, anxiety, PTSD)
- ❑ Migraine headache
- ❑ Multiple sclerosis (neurodegenerative disease)
- ❑ Prostate disease
- ❑ Rheumatic disease (Lupus, Sjogrens, Reiters)
- ❑ Skin disorders (psoriasis, eczema)
- ❑ Sleep disorders (insomnia, sleep apnea)
- ❑ Substance abuse (tobacco, alcohol, other drugs)
- ❑ Weight loss / gain

FEMALES REPRODUCTIVE HISTORY:

Number of pregnancies __________ Number of children __________ Children's present ages ________________

Are you pregnant now? ❑Yes ❑No Are you planning a pregnancy? ❑Yes ❑No

Are you currently breastfeeding? ❑Yes ❑No

PAST SURGICAL HISTORY: *Please list in chronological order surgeries and approximate dates.*

1. ____ Date: ______________
2. ____ Date: ______________
3. ____ Date: ______________

REVIEW OF SYSTEMS

Symptoms: Check [X] symptoms you currently have or have had in the past year.

	GENERAL		GASTROINTESTINAL		EYE, EAR, NOSE, THROAT		MEN only
	Chills		Abdominal pain or cramps		Bleeding gums		Breast lump
	Depression		Appetite poor		Blurred vision		Erection difficulties
	Dizziness		Bloating		Crossed eyes		Lump in testicles
	Fainting		Bowel changes		Difficulty swallowing		Penis discharge
	Fever		Constipation		Double vision		Sore on penis
	Forgetfulness		Diarrhea		Ear discharge		
	Headache		Excessive hunger		Earache		**WOMEN only**
	Loss of sleep		Excessive thirst		Hay fever		Abnormal Pap Smear
	Loss of weight		Gas		Hoarseness		Bleeding between periods
	Nervousness		Hemorrhoids		Loss of hearing		Breast lump
	Numbness		Indigestion		Nosebleeds		Extreme menstrual pain
	Poor energy		Nausea		Persistent cough		Hot flashes
	Sweats		Rectal bleeding		Ringing in ears		Nipple discharge
			Stomach pain		Sinus problems		Painful intercourse
	MUSCLE/JOINT/BONE		Vomiting		Vision — Flashes		Vaginal discharge
	Pain, weakness, numbness in:		Vomiting blood		Vision — Halos		
	Arms [ ] Hips						**ENDOCRINE**
	Back [ ] Legs		**CARDIOVASCULAR**		**INTEGUMENTARY**		Goiter
	Feet [ ] Neck		Cardiac palpitations		Bruise easily		Hot or cold intolerance
	Hands [ ] Shoulders		Chest pain or angina		Change in moles		Sexual dysfunction
	Arthritis [ ] Muscle Cramp		High blood pressure		Hives		
			Irregular heart beat		Itching		**HEMATOLOGIC/ LYMPHATIC**
	GENITO-URINARY		Low blood pressure		Rash		Anemia
	Blood in urine		Poor circulation		Scars		Bleeding tendency
	Frequent urination		Rapid heart beat		Sore that won't heal		Blood disorder
	Lack of bladder control		Swelling of ankles				Blood transfusion
	Painful urination		Varicose veins		**RESPIRATORY**		
	Stones or Gravel				Asthma		
	Urinary leakage		**NEUROLOGICAL**		Bronchitis		
			Disturbance of speech		Cough		
	PSYCHIATRIC		Dizziness, vertigo		Cyanosis		
	Anxiety		Fainting		Painful breathing		
	Depression		Headache		Pneumonia		
	Disturbing feelings		Numbness		Shortness of breath		
	Panic attack		Seizures		Sputum with blood		
	Restlessness		Tingling		Tuberculosis		
			Weakness		Wheezing		

Conditions: Check [X] conditions you currently have or have had in the past year.

	AIDS		Chemical Dependency		High Cholesterol		Prostate Problem
	Alcoholism		Chicken Pox		HIV Positive		Psychiatric Care
	Anemia		Diabetes		Kidney Disease		Rheumatic Fever
	Anorexia		Emphysema		Liver Disease		Scarlet Fever
	Appendicitis		Epilepsy		Measles		Stroke
	Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt
	Asthma		Goiter		Miscarriage		Thyroid Problems
	Bleeding Disorders		Gonorrhea		Mononucleosis		Tonsillitis
	Breast Lump		Gout		Multiple Sclerosis		Tuberculosis
	Bronchitis		Heart Disease		Mumps		Typhoid Fever
	Bulimia		Hepatitis		Pacemaker		Ulcers
	Cancer		Hernia		Pneumonia		Vaginal Infections
	Cataracts		Herpes		Polio		Venereal Disease

CANNABIS USE PATTERN

At what age did you first use cannabis? _____ years old   Was your first use social? ❑Yes ❑No
At what age did you discover that cannabis eased your medical symptoms? _____ years old
What were the circumstances? ____

____

Types: ❑sinsemilla ❑whole plant ❑hashish ❑ kief ❑oil ❑others: ____
Methods of consumption:
❑Inhaled: ❑vapor ❑smoke (❑joint ❑pipe ❑water pipe) ❑others: ____
❑Ingested: ❑tea ❑capsules ❑butter ❑oil ❑tincture ❑baked goods ❑others: ____
❑Rectal / vaginal: ❑suppository ❑others: ____
❑Topical: ❑tincture ❑cream ❑ointment ❑poultice ❑para bath ❑DMSO ❑others: ____

How often do you use cannabis?
❑1 times per month ❑2 – 3 x / week ❑1 x / day ❑2 x / day ❑3 x / day ❑4 x / day ❑> 4 x / day
Estimate the average amount of cannabis you use per day? *(large joint = 1 gram, 1/8 oz. = 3.5 gm)*
❑< 1 gram ❑1 gram ❑2 grams ❑3 grams ❑4 grams ❑5 grams ❑6 grams ❑others: _______

Would you use more if it were: 1) easier to obtain? Yes / No 2) cheaper to obtain? Yes / No
How much more? ❑25% ❑50% ❑75% ❑100% ❑Others: ________
Has the amount of cannabis needed to control your symptoms changed over time?
❑much more ❑little more ❑about the same ❑little less ❑much less ❑variable
If changed, to what do you attribute the change: ____

____
How effective is cannabis in treating your condition?
❑Much better (very effective) ❑Better (effective) ❑Slightly better (somewhat effective)

How does cannabis compare with your usual prescribed medicines in relieving your symptoms?
❑Prescribed medicines work much better ❑Cannabis works a little better than prescribed medicines
❑Prescribed medicines work a little better ❑Cannabis works much better than prescribed medicines
❑Prescribed medicines work no better ❑Cannabis and prescribed medicines work best together
Explain: ____
Have you ever stopped using cannabis only to find that your symptoms return or worsen? ❑Yes ❑No
Explain: ____
If your symptoms disappear or are substantially reduced would you keep on using cannabis? ❑Yes ❑No
Have you ever used synthetic THC (Marinol)? ❑Yes ❑No
If yes, compare effect of Marinol to natural cannabis: ______________________________
Does use of cannabis modifies your use of other drugs? ❑Yes ❑No Explain: ________________
Does use of cannabis modify your use of alcohol? ❑Yes ❑No Explain: ________________
Do you use, or have you used an antidepressant (SSRI) and cannabis together? ❑Yes ❑No
If yes, describe the effect of each. Antidepressant: ______________ Cannabis: ______________
Describe bothersome adverse effects that you have to cannabis: ______________________________
Are there other reasons for which you use cannabis? ______________________________
Has your cannabis use affected your relationship with your family?
❑no change ❑slightly ❑a lot ❑not applicable

DEVELOPMENTAL HISTORY

Childhood: ❑ Illnesses ❑ Injury If so, please explain:____________________
Breastfed: ❑ Yes ❑ No ❑ Uncertain
Dominant Hand: ❑ Right ❑ Left ❑ Ambidextrous
Parenting: ❑ Two parents ❑ One parent ❑ Others: ____________________________
Your religion: ____________________________ Your parent's religion: ______________________________
Hours of TV / Day: Preschool: _______ Grade school: ________ Middle school: ________ High school: _____

Were you subject to abuse in home life ❑ Yes ❑ No Explain ____________________
Did you change schools frequently? ❑ Yes ❑ No Explain ____________________
Did you have reading or learning disabilities? ❑ Yes ❑ No Explain ____________________
Did you have behavior problems in school? ❑ Yes ❑ No Explain ____________________
Were you a bully or subject to bullying in school? ❑ Yes ❑ No Explain ____________________
Did you take prescription medication for behavior or mood problems in school? ❑ Yes ❑ No Explain ____________________
Are you familiar with ADD? ❑ Yes ❑ No Explain ____________________
Do you think the diagnosis applies to you? ❑ Yes ❑ No Explain ____________________
Did you begin regular alcohol or drug use in school? ❑ Yes ❑ No Explain ____________________

IMMUNIZATION RECORD: *(please ✓ those that are most applicable to you)*

- ❑ MMR (Measles/ Mumps/ Rubella)
- ❑ Polio, DPT (Diphtheria/ Pertussis/ Tetanus)
- ❑ Pneumococcal, Flu Shots
- ❑ Hepatitis A, Hepatitis B
- ❑ Meningococcus, Hemophilus
- ❑ Chicken Pox
- ❑ Others: ____________________________

How many years since your last: Tetanus: _______________
How many years since your last: TB skin test: ____________ Chest X Ray ____________________________

SOCIAL QUESTIONS:

Do you suffer from household stress? ❑ Yes ❑ No Explain ____________________
Are you a child of an alcoholic family? ❑ Yes ❑ No Explain ____________________
Are you an alcoholic? ❑ Yes ❑ No Explain ____________________
Have you ever blacked out? ❑ Yes ❑ No Explain ____________________
Do you feel unsafe in your home? ❑ Yes ❑ No Explain ____________________
Do you feel unsafe in your community? ❑ Yes ❑ No Explain ____________________
When is your last sexual activity? ____
Do you practice safe sex? ❑ Yes ❑ No Explain ____________________
Do you use the followings? ❑ birth control pills ❑ condoms ❑ others ______

MEDICAL LEGAL

Do you understand California's Proposition 215 medical use of marijuana initiative statute? ❑ Yes ❑ No Explain ____________________
Are you on probation or parole? ❑ Yes ❑ No Explain ____________________
Do you have a pending cannabis case? ❑ Yes ❑ No Explain ____________________
Are you subject to workplace drug testing? ❑ Yes ❑ No Explain ____________________
Would you like to be contacted for participation in cannabis clinical research studies? ❑ Yes ❑ No Explain ____________________
Is there any other information the doctor should be aware of? ❑ Yes ❑ No Explain ____________________

Name *(last, first)*: ______________________ DOB: ______________ Today's Date: ______________

❑ Bakersfield ❑ Westwood ❑ Whittier ❑ _______ Documentations: ❑ medication bottles ❑ paper ❑ ______

Patient is ___________ y/o [❑ asian ❑ hispanic ❑ afro-american ❑ caucasian ❑ others: _______________] ❑ female ❑ male.

HPI:

Chief Complaint:	1.	2.	3.
Onset:	[❑ days ❑ weeks ❑ months ❑ years]	[❑ days ❑ weeks ❑ months ❑ years]	[❑ days ❑ weeks ❑ months ❑ years]
Palliative:	Rx____________	Rx____________	Rx____________
	❑ with ❑ without improvement.	❑ with ❑ without improvement.	❑ with ❑ without improvement.
	❑ nausea ❑ gastritis ❑ constipation	❑ nausea ❑ gastritis ❑ constipation	❑ nausea ❑ gastritis ❑ constipation
	❑ worsen sx ❑ ____________	❑ worsen sx ❑ ____________	❑ worsen sx ❑ ____________
Quality:	❑ sharp ❑ dull ❑ wrenching	❑ sharp ❑ dull ❑ wrenching	❑ sharp ❑ dull ❑ wrenching
Radiation:	❑ radiates to ____________	❑ radiates to ____________	❑ radiates to ____________
	❑ non-radiation	❑ non-radiation	❑ non-radiation
Severity:	[❑ 2 ❑ 4 ❑ 6 ❑ 8 ❑ 10]	[❑ 2 ❑ 4 ❑ 6 ❑ 8 ❑ 10]	[❑ 2 ❑ 4 ❑ 6 ❑ 8 ❑ 10]

PMedHx: ❑ unchanged ❑ others: ______________________________

❑ DM ❑ HTN ❑ Hyperlipidemia ❑ LBP ❑ Leg Pain ❑ CVD ❑ CAD❑ CHF ❑ Hepatitis ❑ TB ❑ HIV ❑ DVT

PSurgHx: ❑ unchanged

1.______________________________ Date ____________

2.______________________________ Date ____________

FamHx:

father: ❑ died ❑ alive with ____________ siblings: [❑ sister ❑ brother] ❑ died ❑ alive with ____________

mother: ❑ died ❑ alive with ____________ siblings: [❑ sister ❑ brother] ❑ died ❑ alive with ____________

siblings: [❑ sister ❑ brother] ❑ died ❑ alive with ____________

SocHx: ❑ tobacco ______ pack /d ___________ years ❑ alcohol ____________ oz. for _____ /d

Pharmacological Management: *(medication, dosage, frequency)* ❑ unchanged

1. ______________ ______________ ____________ 3. ______________ ______________ ____________

2. ______________ ______________ ____________ 4. ______________ ______________ ____________

Allergy: ❑ NKDA 1.______________________ ❑ rash ❑ edema ❑ convulsion ❑ intubation

2.______________________ ❑ rash ❑ edema ❑ convulsion ❑ intubation

VS: hgt. _______ ins. wgt. ________ lbs. BMI________ BP_____/_____ T_______ P________ R_______ SpO2; ______

PExam:

General Appearance:	❑ WNL *NAD AAOx3 WD WN Aw AL*	❑ others: ______________
Integument:	❑ WNL	❑ pale ❑ erythema ❑ lesion ❑ hair loss ❑ swelling ❑ itching ❑ rash ❑ others: ________
HEENT:	❑ WNL *NC/AT PERRLA EOM-I, clear sclerae, pink conjunct. TM-nonerythem.*	❑ red sclera ❑ tearing ❑ hypertrophic turbinates ❑ immobile TM ❑ others:______________
Neck:	❑ WNL *supple trachea midline*	❑ JVD ❑ thyromegaly ❑ bruit ❑ stridor ❑ LAD ❑ LAP
Chest:	❑ WNL *CTA-B, vocal fremitus, resonant-B*	❑ wheezing ❑ rale ❑ rhonchi ❑ crackles
CV:	❑ WNL *RRR, audible S1 S2, PMI 5th ICS MCL*	❑ murmur ❑ gallops ❑ rub ❑ click location: ______________
ABD:	❑ WNL *soft NABS flatus, BM,*	❑ tender [❑ guarded ❑ rebound] ❑ distended ❑ HSM ❑ visceromegaly ❑ hyperactive BS ❑ quiet BS ❑ scar ❑ HJR ❑ RUQ ❑ RLQ❑ LUQ❑ LLQ ❑ epigastrium ❑ periumbilical
EXT: (neuro)	❑ WNL *warm DTR intact, capillary refill <2 sec., PPx4*	❑ edema [❑ pitting❑ non-pitting] ❑ clubbing ❑ cyanosis ❑ tenderness [❑ upper ❑ lower]
		❑ diminished pulse ❑ cold ❑ torturous varicosity
motor	❑ WNL *FROM* strength:[❑ 2 ❑ 3 ❑ 4 ❑ 5]	❑ abn. gait
sensation		❑ numbness ❑ tingling ❑ burn-like ❑ diminished vibration
spine:	❑ WNL *straight*	❑ kyphosis❑ lordosis ❑ scoliosis ❑ CVAT [❑R ❑L] ❑ tenderness [❑ cervical ❑ thoracic ❑ lumbar] [❑ neutral ❑ flexion ❑ extension ❑ side bending ❑ rotation]

Assessment:

❑ Anorexia **783.0**	❑ Cancer **199.1**	❑ Endometriosis **617.9**	❑ Headache **784.0**	❑ Irritable bowel **564.1**	❑ PTSD **309.81**
❑ Arthritis **715**	❑ Carpal tunnel **354.0**	❑ Epilepsy **345.9**	❑ Hepatitis C **070.54**	❑ Menst cramp **625.9**	❑ Restless leg **333.99**
❑ Cachexia **799.4**	❑ Crohn's **555.9**	❑ Extrapyram **333.9**	❑ Herniated disc **722.2**	❑ Movemt d/o **333**	❑ Rheumatoid **714**
❑ Anxiety **308.0**	❑ Depression **311**	❑ Fibromyalgia **729.1**	❑ HIV **042**	❑ Multiple sclero **340**	❑ Spasticity **781.0**
❑ Asthma **493.9**	❑ Diab Mellitus **250**	❑ Gastritis **535.5**	❑ Hypertension **402.00**	❑ Nausea Vomit **787.0**	❑ Spinal injury **957**
❑ Attention def **314.0**	❑ Diab Neuro **250.60**	❑ Glaucoma **365.9**	❑ Insomnia **780.52**	❑ Periph neuro **357**	❑ Ulcer colitis **556.9**
❑ Bipolar **296.8**	❑	❑	❑	❑	❑

Plan:

❑ THC [❑ vapor ❑ edible] [❑ indica ❑ sativa ❑ hybrid] ❑ counsel pros/cons of cannabis ❑ ask patient to inform PCP w cannabis

❑ diet (fruits & vegs, no fat) ❑ daily exercise 20 – 30 mins ❑ oral fluid 6 – 8 glasses daily ❑ smoking cessation ❑ "exercise your legal rights"

RTC for additional evaluation in: ❑ 3-mos. ❑ 6-mos. ❑ 1-year

Recommendations: ❑ observation ❑ continuing present mgt ❑ additional tx

______________________________ ***Date:*** ______________________ ❑ Chart Reviewed

Physician's Signature

ACKNOWLEDGEMENT AND CONSENT

Initials

__________ I acknowledge that using cannabis as medicine has been explained to me and that any questions that I have asked have been answered to my satisfaction.

__________ I have discussed and been informed of the potential benefits and risks of using cannabis with the medical practitioner.

__________ I know that I may ask now, or in the future, any questions I have about my treatment.

__________ I voluntarily consent to receive medical and health care services from the Total Health Care Clinic.

__________ I have been assured that records relating to my care will be kept confidential and that no information will be released or printed that would disclose personal identity, unless required by law.

__________ I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of marihuana as a drug. I understand the significance of this fact.

__________ I consent to using marijuana only for the treatment of the symptom stated in the medical declaration.

__________ I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified; and I accept those risks.

__________ I am aware that medical cannabis has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

__________ If the daily amount stated is more than five grams; I understand the potential risks associated with an elevated daily consumption of marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency.

__________ I accept all the aforementioned risks and will not hold the Total Health Care Clinic or the Physician responsible for any legal ramifications.

__________ I attest that the information on this form is correct and any medical history presented to the doctor is also factual and complete.

Patient's Signature________________________________ Date_______________________

RELEASE OF LIABILITY

I attest that the information on this form is correct and any medical history presented or discussed with the doctor is also factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical cannabis. Solely for verification purposes, I authorize the Total Health Care Clinic to converse of my medical condition.

I understand that I must be a California State resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under California's Compassionate Use Act of 1996 (Health & Safety Code #11362.5).

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis (medical marijuana) provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. I understand the potential risks associated with an elevated daily consumption of marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of this plant as medication, I assume full responsibility for any and all risks of this action.

I am advised that the cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician.

I was further advised that the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

California's Compassionate Use Act of 1996, (Health & Safety Code #11362.5), provides for the possession and cultivation of cannabis (medical marijuana) for the personal medical purposes of the patient with a physician approval or recommendation. It should be made absolutely clear that the physician, staff and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in my obtaining cannabis (medical marijuana).

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal cannabis treatment. I acknowledge that using cannabis as medicine has been explained to me and that any questions that I have asked have been answered to my satisfaction. There are no claims about the medical efficacy of cannabis. The physician, staff, and representatives are addressing specific aspects of my medical care, and, unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of cannabis, I understand that there is a renewal date specified by the physician. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval. Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of cannabis.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of cannabis treated patients.

Signature: ________________________ **Date:** ________________

Patient or Minor patient's parent or legal guardian

____

Print Name: *Last, First*

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any claim of malpractice, including any claim that health care services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered or omitted, will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The patient has the right to seek legal counsel concerning this agreement, and has the right to rescind this agreement by written notice to the physician within ninety days after the agreement has been signed and executed by both parties unless said agreement was signed in contemplation of this patient being hospitalized, in which case the agreement may be rescinded by written notice to the physician within ninety days after release or discharge from the hospital or other health care institution. Both parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all patient claims that may arise out of or related to treatment or services provided by the physician including any heirs or past, present or future spouse(s) of the patient in relation to all occurrence giving rise to any claim. This agreement is intended to bind any children of the patient whether born or unborn at the time of the providers or preceptorship interns who now or in the future treat the patient while employed by working or associated with or serving as a back-up for the physician, including those working at the physician's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court proceeding by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issue of liability and damage upon written request to the neutral arbitrator The parties consent to the intervention and joiner in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration. The introduced evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages confirmed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the arbitration conducted pursuant to this Arbitration Agreement shall be final and binding. The prevailing party shall be entitled to reasonable fees incurred due to the arbitration, including arbitration fees, counsel fees, witness fees, or other expenses incurred by the prevailing party.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 90 days of signature and if not revoked will govern all professional services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here ____. Effective as of the date of first professional services.

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING RIGHT TO A JURY OR COURT TRIAL: SEE ARTICLE I OF THIS CONTRACT.

By: ____________________	________	By: ____________________	________
Patient or Patient Representative Signature	(Date)	Physician or Authorized Representative Signature	(Date)
Print Patient Name	(Date)	Print Physician or Authorized Representative Name	(Date)

Rev. 12/07