

**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 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> 6<sup>th</sup> 7<sup>th</sup> \_\_\_\_\_ 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.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Flurbiprofen   | <input type="checkbox"/> Pamelor       |
| <input type="checkbox"/> Ambien        | <input type="checkbox"/> Forte          | <input type="checkbox"/> Parafon       |
| <input type="checkbox"/> Amitriptyline | <input type="checkbox"/> Gabapentin     | <input type="checkbox"/> Paroxetine    |
| <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Halcion        | <input type="checkbox"/> Paxil         |
| <input type="checkbox"/> Atarax        | <input type="checkbox"/> Hydrocodone    | <input type="checkbox"/> Percocet      |
| <input type="checkbox"/> Baclofen      | <input type="checkbox"/> Hydromorphone  | <input type="checkbox"/> Phenytoin     |
| <input type="checkbox"/> Benadryl      | <input type="checkbox"/> Hydroxyzine    | <input type="checkbox"/> Piroxicam     |
| <input type="checkbox"/> Bupropion     | <input type="checkbox"/> Ibuprofen      | <input type="checkbox"/> Prednisone    |
| <input type="checkbox"/> BuSpar        | <input type="checkbox"/> Imipramine     | <input type="checkbox"/> Pregablin     |
| <input type="checkbox"/> Cannabinoids  | <input type="checkbox"/> Indocin        | <input type="checkbox"/> Propoxyphene  |
| <input type="checkbox"/> Capsaicin     | <input type="checkbox"/> Indomethacin   | <input type="checkbox"/> Prozac        |
| <input type="checkbox"/> Carbamazepine | <input type="checkbox"/> Ketoprofen     | <input type="checkbox"/> Robaxin       |
| <input type="checkbox"/> Celebrex      | <input type="checkbox"/> Ketorolac      | <input type="checkbox"/> Roxicodone    |
| <input type="checkbox"/> Clonazepam    | <input type="checkbox"/> Lamictal       | <input type="checkbox"/> Salsalate     |
| <input type="checkbox"/> Codeine       | <input type="checkbox"/> Lamotrigine    | <input type="checkbox"/> Sinequan      |
| <input type="checkbox"/> Cymbalta      | <input type="checkbox"/> Levorphanol    | <input type="checkbox"/> Soma          |
| <input type="checkbox"/> Dalmane       | <input type="checkbox"/> Lidocaine      | <input type="checkbox"/> Sulindac      |
| <input type="checkbox"/> Darvocet      | <input type="checkbox"/> Lyrica         | <input type="checkbox"/> Tegretol      |
| <input type="checkbox"/> Darvon        | <input type="checkbox"/> Meclofenamate  | <input type="checkbox"/> Tofranil      |
| <input type="checkbox"/> Depakote      | <input type="checkbox"/> Mefenamic acid | <input type="checkbox"/> Tolmetin      |
| <input type="checkbox"/> Desipramine   | <input type="checkbox"/> Meperidine     | <input type="checkbox"/> Topamax       |
| <input type="checkbox"/> Dexamethasone | <input type="checkbox"/> Methadone      | <input type="checkbox"/> Topiramate    |
| <input type="checkbox"/> Diazepam      | <input type="checkbox"/> Mexiletine     | <input type="checkbox"/> Tramadol      |
| <input type="checkbox"/> Diclofenac    | <input type="checkbox"/> Morphine       | <input type="checkbox"/> Trilisate     |
| <input type="checkbox"/> Diflunisal    | <input type="checkbox"/> MS-Contin      | <input type="checkbox"/> Tylenol #3    |
| <input type="checkbox"/> Dilantin      | <input type="checkbox"/> Nabumetone     | <input type="checkbox"/> Tylenol #4    |
| <input type="checkbox"/> Doxepin       | <input type="checkbox"/> Naprosyn       | <input type="checkbox"/> Ultram        |
| <input type="checkbox"/> Duloxetine    | <input type="checkbox"/> Naproxen       | <input type="checkbox"/> Valium        |
| <input type="checkbox"/> Effexor       | <input type="checkbox"/> Neurontin      | <input type="checkbox"/> Valproic acid |
| <input type="checkbox"/> Elavil        | <input type="checkbox"/> Norflex        | <input type="checkbox"/> Venlafaxine   |
| <input type="checkbox"/> Etodolac      | <input type="checkbox"/> Norpramin      | <input type="checkbox"/> Vicodin       |
| <input type="checkbox"/> Fenoprofen    | <input type="checkbox"/> Nortriptyline  | <input type="checkbox"/> Vioxx         |
| <input type="checkbox"/> Fentanyl      | <input type="checkbox"/> Oramorph SR    | <input type="checkbox"/> Vistaril      |
| <input type="checkbox"/> Flecainide    | <input type="checkbox"/> Oxaprozin      | <input type="checkbox"/> Wellbutrin    |
| <input type="checkbox"/> Flexeril      | <input type="checkbox"/> Oxycodone      | <input type="checkbox"/> Xanax         |
| <input type="checkbox"/> Fluoxetine    | <input type="checkbox"/> Oxycontin      | <input type="checkbox"/> Zoloft        |
|  | <input type="checkbox"/> Oxymorphone    | <input type="checkbox"/> 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, no solid evidence that smoking marijuana creates any greater benefits than approved medications (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.

**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: Maternal 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)

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Back and neck pain</li> <li><input type="checkbox"/> Blood Disorders (anemia, abnormal clotting)</li> <li><input type="checkbox"/> Brain disorders (epilepsy, trauma, etc)</li> <li><input type="checkbox"/> Breast lesions</li> <li><input type="checkbox"/> Cancer, specify:</li> <li><input type="checkbox"/> Chronic pain, specify:</li> <li><input type="checkbox"/> Circulation (stroke, phlebitis, etc)</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Dystonia (spasms, tremors, Parkinson's)</li> <li><input type="checkbox"/> Ear problems (tinnitus, hearing loss)</li> <li><input type="checkbox"/> Eating disorder (anorexia, bulimia)</li> <li><input type="checkbox"/> Endocrine problems (thyroid, hormones)</li> <li><input type="checkbox"/> Eye problems (glaucoma, cataracts)</li> <li><input type="checkbox"/> Genital / GYN problems</li> <li><input type="checkbox"/> Heart disease</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Herpes zoster / shingles / other</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Intestinal disorders (ulcers, colitis, IBS)</li> <li><input type="checkbox"/> Kidney disease (cystitis, renal failure)</li> <li><input type="checkbox"/> Liver disease (cirrhosis, hepatitis B or C)</li> <li><input type="checkbox"/> Lungs disease (asthma, emphysema)</li> <li><input type="checkbox"/> Mental disorders (depression, anxiety, PTSD)</li> <li><input type="checkbox"/> Migraine headache</li> <li><input type="checkbox"/> Multiple sclerosis (neurodegenerative disease)</li> <li><input type="checkbox"/> Prostate disease</li> <li><input type="checkbox"/> Rheumatic disease (Lupus, Sjogrens, Reiters)</li> <li><input type="checkbox"/> Skin disorders (psoriasis, eczema)</li> <li><input type="checkbox"/> Sleep disorders (insomnia, sleep apnea)</li> <li><input type="checkbox"/> Substance abuse (tobacco, alcohol, other drugs)</li> <li><input type="checkbox"/> Weight loss / gain</li> </ul> |
|---|---|

**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		<b>WOMEN only</b>	
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	
		Vomiting		Vision — Flashes		Vaginal discharge	
		Vomiting blood		Vision — Halos			
<b>MUSCLE/JOINT/BONE</b>						<b>ENDOCRINE</b>	
<i>Pain, weakness, numbness in:</i>							
Arms	Hips						
Back	Legs	<b>CARDIOVASCULAR</b>		<b>INTEGUMENTARY</b>		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		<b>HEMATOLOGIC/ LYMPHATIC</b>	
<b>GENTO-URINARY</b>		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		<b>RESPIRATORY</b>			
Stones or Gravel				Asthma			
Urinary leakage		<b>NEUROLOGICAL</b>		Bronchitis			
		Disturbance of speech		Cough			
<b>PSYCHIATRIC</b>		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:**

<b>Chief Complaint:</b>	1. _____	2. _____	3. _____
Onset:	[ <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years]	[ <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years]	[ <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> months <input type="checkbox"/> years]
Palliative:	Rx _____ <input type="checkbox"/> with <input type="checkbox"/> without improvement. <input type="checkbox"/> nausea <input type="checkbox"/> gastritis <input type="checkbox"/> constipation <input type="checkbox"/> worsen sx <input type="checkbox"/> _____	Rx _____ <input type="checkbox"/> with <input type="checkbox"/> without improvement. <input type="checkbox"/> nausea <input type="checkbox"/> gastritis <input type="checkbox"/> constipation <input type="checkbox"/> worsen sx <input type="checkbox"/> _____	Rx _____ <input type="checkbox"/> with <input type="checkbox"/> without improvement. <input type="checkbox"/> nausea <input type="checkbox"/> gastritis <input type="checkbox"/> constipation <input type="checkbox"/> worsen sx <input type="checkbox"/> _____
Quality:	<input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> wrenching	<input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> wrenching	<input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> wrenching
Radiation:	<input type="checkbox"/> radiates to _____ <input type="checkbox"/> non-radiation	<input type="checkbox"/> radiates to _____ <input type="checkbox"/> non-radiation	<input type="checkbox"/> radiates to _____ <input type="checkbox"/> non-radiation
Severity:	[ <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 8 <input type="checkbox"/> 10]	[ <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 8 <input type="checkbox"/> 10]	[ <input type="checkbox"/> 2 <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 8 <input type="checkbox"/> 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 \_\_\_\_\_

**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; \_\_\_\_\_

**PEExam:**

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

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

**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

\_\_\_\_\_  
*Physician's Signature* Date: \_\_\_\_\_  Chart Reviewed

## 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 joinder 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 joinder 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: _____ Patient or Patient Representative Signature (Date)	By: _____ Physician or Authorized Representative Signature (Date)
_____ Print Patient Name (Date)	_____ Print Physician or Authorized Representative Name (Date)

Rev. 12/07