CANNACAREDOCS

(781) 382-8053
info@cannacaredocs.com

Patient Medical History Form

Name ______________________ **Date of birth** ______________________

Address ______________________

City ______________________ **State** __________ **Zip** __________

Phone ______________________ **E-mail** ______________________

Emergency contact ______________________ **Phone** ______________________

Gender:

- ○ Female
- ○ Male
- ○ Prefer not to say
- ○ Other (please specify): ______________________

Ethnicity:

- ○ American Indian/Native
- ○ Asian
- ○ Black/African American
- ○ Hispanic
- ○ Middle Eastern
- ○ Native Hawaiian or Other Pacific Islander
- ○ South East Asian
- ○ White/Caucasian
- ○ Other (please specify): ______________________

Do you have a severe cardiac condition? ○ Yes ○ No

Do you smoke tobacco? ○ Yes ○ No

How much/how often? ______________________

Do you drink alcohol? ○ Yes ○ No

How much/how often? ______________________

Do you use illicit drugs (non-cannabis)? ○ Yes ○ No

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Do you have history of drug abuse? ○ Yes ○ No

If yes, which drug? ______________________

Have you abstained from using any substances of abuse for 5 years or more? ○ Yes ○ No

Are you currently on:

- ○ Methadone Replacement Therapy
- ○ Suboxone Replacement Therapy
- ○ Alcohol Withdrawal Management Program
- ○ Addictions Related Mental Health Counseling

Do you have family history of psychosis? ○ Yes ○ No

Do you have family history of schizophrenia? ○ Yes ○ No

Do you have family history of cardiac conditions? ○ Yes ○ No

Are you currently pregnant, plan on becoming pregnant or breastfeeding? ○ Yes ○ No

Primary condition (please select one primary condition):

- ○ ADD/ADHD
- ○ Alzheimer's Disease
- ○ Anorexia
- ○ Anxiety
- ○ Appetite Stimulation
- ○ Arthritis
- ○ Back & Neck Problems
- ○ Cachexia/Wasting Syndrome
- ○ Cancer Related Pain
- ○ Chemotherapy Induced Nausea
- ○ Chronic Nausea
- ○ Chronic Pain
- ○ Colitis
- ○ Crohn's Disease
- ○ Depression
- ○ Dravet Syndrome
- ○ Epilepsy
- ○ Fibromyalgia
- ○ Glaucoma
- ○ Headaches
- ○ Hepatitis C
- ○ HIV/AIDS
- ○ Insomnia
- ○ Irritable Bowel Syndrome
- ○ Irritable Bowel Syndrome
- ○ Mood Disorders
- ○ Movement Disorder
- ○ Multiple Sclerosis
- ○ Muscle Spasm
- ○ Neuropathic Pain
- ○ Obesity
- ○ Obsessive Compulsive Disorder
- ○ Opiate Dependence
- ○ Parkinson's
- ○ PTSD
- ○ Scoliosis
- ○ Spinal Cord Injury/Disease
- ○ Stress
- ○ Tremors
- ○ Other (please specify): ______________________

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Secondary condition (please select all that apply):

- ADD/ADHD
- Alzheimer's Disease
- Anorexia
- Anxiety
- Appetite Stimulation
- Arthritis
- Back & Neck Problems
- Cachexia/Wasting Syndrome
- Cancer Related Pain
- Chemotherapy Induced Nausea
- Chronic Nausea
- Chronic Pain
- Colitis
- Crohn's Disease
- Depression
- Dravet Syndrome
- Epilepsy
- Fibromyalgia
- Glaucoma
- Headaches
- Hepatitis C
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- Neuropathic Pain
- Obesity
- Obsessive Compulsive Disorder
- Opiate Dependence
- Parkinson's
- PTSD
- Scoliosis
- Spinal Cord Injury/Disease
- Stress
- Tremors
- Other (please specify): ____________________

Current medications (please include dose): ____________________

Previous medications (please include dose): ____________________

Therapies tried (please indicate if you tried them in the past):

Therapy	Past	Therapy	Past
Acudetox	○	Homeopathic Medicine	○
Acupuncture	○	Massage Therapy	○
Addictions Counseling	○	Mental Health Counseling	○
Aroma Therapy	○	Mindfulness-Based Cognitive Therapy	○
Chiropractor	○	Naturopathic Medicine	○
Cognitive Behavior	○	Physiotherapy	○
Exercise	○	Reiki	○

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Past surgical history: ______________________________

Hospitalization/serious illness: ______________________________

Allergies: ______________________________

GAD (Generalized Anxiety Disorder)

Over the last two weeks, how often have you been bothered by the following problems:	Not At All	Several Days	Over ½ days	Everyday
1. Feeling nervous, anxious or on edge	○	○	○	○
2. Not being able to stop or control worrying	○	○	○	○
3. Worrying too much about things	○	○	○	○
4. Trouble relaxing	○	○	○	○
5. Being so restless that it's hard to sit still	○	○	○	○
6. Becoming easily annoyed or irritable	○	○	○	○
7. Feeling afraid as if something awful might happen	○	○	○	○

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?

○ Not difficult ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Do you have experience with cannabis? ○ Yes ○ No

Average dosage: ______________ Cannabinoid Profile Ratio (THC:CBD): ______________

How often do you use cannabis?
- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ In the past

What time of day?
- ○ Morning
- ○ Afternoon
- ○ Evening
- ○ Night

What mode of administration?
- ○ Topical
- ○ Inhalation
- ○ Oral
- ○ Oromucosal

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Which of the positive effects have you experienced?

- ○ Energetic
- ○ Euphoric
- ○ Improved Appetite
- ○ Improved Fatigue
- ○ Improved Mood
- ○ Improved Sleep
- ○ Improvement in Relations
- ○ Increase in Mobility
- ○ Increased Creativity
- ○ Increased Focus
- ○ Increased Motivation
- ○ Increased Productivity
- ○ Pain Reduction
- ○ Reduced Anxiety
- ○ Reduced Bowel Movements
- ○ Other (please specify): ____________________
- ○ Reduced Headache/Migraine
- ○ Reduced Nausea
- ○ Reduced Seizure Activity
- ○ Reduced Stress
- ○ Reduced Vomiting
- ○ Relaxed
- ○ Uplifted

Notes: ____________________

Which of the following negative side effects have you experienced?

- ○ Dizziness
- ○ Dry Mouth
- ○ Increased Anxiety
- ○ Memory Loss
- ○ Drowsiness
- ○ Fatigue
- ○ Increased Appetite
- ○ Paranoia
- ○ Dry Eyes
- ○ Headache
- ○ Increased Heart Rate
- ○ Red Eyes
- ○ Other (please specify): ____________________

Notes: ____________________

How did you hear about Canna Care Docs?

- ○ Google
- ○ Leafly/Weedmaps
- ○ Marijuana Doctor
- ○ Newspaper
- ○ Social Media
- ○ Television
- ○ Flyer (please indicate where): ____________________
- ○ Referral (please indicate who): ____________________

By signing this document you declare that you have truthfully and completely disclosed all information regarding your medical and behavioral health conditions.

Patient Name (please print) ____________________ Date ____________

Patient Signature ____________________

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