Patient Information

Name: (Last, First, Middle): _____

Preferred Name/What name would you like us to use: _____

Birthdate:_____ Phone Number: _____

Social Security Number (used for recommendation form only): _____

Address: _____

Email address: _____

Emergency Contact: (name, phone number): _____

Purpose of Visit: [ ] initial medical marijuana evaluation [ ] follow-up visit [ ] other

Where did you find out about our clinic? _____

Medical History

Primary Condition or Symptoms to be addressed at today's visit: _____

_____

_____

_____

How long have you had the condition/symptoms above? _____

_____

What therapies are you currently using to address your condition/symptoms?

_____

_____

What therapies have you tried in the past? _____

_____

_____

_____

Have you tried marijuana, CBD, THC, or other similar therapies for medical purposes? If so, how have they affected you? _____

_____

_____

Current Medications, Supplements, and Vitamins (include over the counter medications):

_____

_____

_____

_____

_____

Please list ALL of your past and current medical diagnoses/problems: _____

_____

_____

_____

_____

_____

Gender: Female [ ] Male [ ]

Female patients: Are you pregnant? [ ]no [ ] yes [ ] not sure

Are you considering becoming pregnant in the next two years? [ ] no [ ] yes

Surgical History: (please list all surgeries and dates):

_____

_____

_____

Family history of psychiatric disorders? [ ] no [ ] yes. If so, what conditions? _____

_____

Habits:

Do you smoke cigarettes? [ ] no [ ] yes if yes, number of packs per week: _____

Do you drink alcohol? [ ] no [ ] yes if yes, number of drinks per week: _____

Do you use other drugs? [ ] no [ ] yes if yes, what do you use and how often?

_____

Do you use caffeine? [ ] no [ ] yes if yes, how much per week? _____

Do you exercise? [ ] no [ ] yes if yes, how many hours per week? _____

Do you drive? [ ]no [ ] yes Are there children in your home? [ ]no [ ] yes

Review of Systems:

Are you experiencing problems with any the following (if other, please list):

	YES	NO	
HEAD:	_____	_____	severe headache, brain aneurysm, other_____
EYES:	_____	_____	glaucoma, cataracts, blurred vision, blindness, other _____
EARS:	_____	_____	deafness, hearing loss, vertigo, ringing in ears, other _____
NOSE:	_____	_____	nose bleeds, nasal congestion, sinus infections, other _____
THROAT:	_____	_____	mouth sores, sore throat, hoarse voice, other _____
CHEST:	_____	_____	COPD, asthma, cough, tuberculosis, lung infections, other _____
ABDOMEN:	_____	_____	liver disease, hepatitis, pancreatitis, gallstones, other _____
GI:	_____	_____	severe nausea, acid reflex, blood in stool, ulcers, other _____
GU	_____	_____	kidney stones, UTIs, vaginal bleeding, prostate problems, other _____
INFECTIONS:	_____	_____	HIV, AIDS, frequent or unusual infections, other _____
MSK:	_____	_____	arthritis, back pain, joint pain, muscle pain, cramps, other _____
RHEUM:	_____	_____	lupus, rheumatoid arthritis, fibromyalgia, other _____
HEME:	_____	_____	bleeding disorder, clotting disorders, swollen glands, other _____
SKIN:	_____	_____	skin cancer, rash, psoriasis, other _____
ENDOCRINE:	_____	_____	diabetes; thyroid, pituitary, or hormonal problems, other _____
NEUROLOGIC:	_____	_____	seizures, stroke, paralysis, tremors, dizziness, migraines, cerebral palsy, autism, neuropathy, Parkinson's disease, Alzheimer's disease, other _____ _____
PSYCHIATRIC:	_____	_____	PTSD, anxiety, depression, suicidal thoughts, other _____
ONOCOLOGIC:	_____	_____	active cancer, cancer in remission, MDS, MM, other _____

Please explain anything specific you would like to discuss with your healthcare provider today:

_____

_____

_____

_____

We are establishing a physician-patient relationship to determine if a recommendation for the safe and therapeutic use of medical cannabis/marijuana can be made and NOT for any other purpose. You are advised to consult with your primary care provider at least once a year for re-evaluation of your diagnoses and treatment plan.

Please read thoroughly and INITIAL below:
_____ I have access to the Guide to Using Medical Cannabis (naturalremedymo.com)
_____ I have access to up to date information regarding state laws surrounding medical cannabis (state medical marijuana website: https://health.mo.gov/safety/medical-marijuana).
_____ I have read and have access to the Natural Remedy MD HIPPA patient privacy policy (included with this form)

I, _____, understand that the purpose of my visit today is for my physician is to determine if it is safe and appropriate for me to obtain a recommendation for medical cannabis.

I, _____, understand that my physician's ability to determine the appropriateness for a recommendation for a medical cannabis/marijuana card is based on my medical history, current medical status, history of drug or medication abuse, physical exam, and medical records. I CERTIFY ALL INFORMATION I HAVE PROVIDED IS ACCURATE.

I, _____, understand that I am not receiving a comprehensive medical evaluation as one would expect from their primary care provider. I understand this evaluation is intended to focus on the factors/conditions relating to a recommendation for a medical cannabis therapy. It is not intended to replace, supersede, or modify any treatment or recommendation of my primary care provider.

I, _____, understand that it is my responsibility to ensure my primary care provider is aware of and approves of my intentions regarding the use of medical cannabis.

I, _____, understand that my recommendation is valid for one year after the issue date or as long as the state of Missouri honors the license associated with the recommendation, whichever is longer. I understand this recommendation is valid for the State of Missouri only. My physician has the right to reverse a recommendation decision at his or her discretion at any time.

I, _____, understand that the physician providing this medical evaluation is available for follow-up care for any and all matters related to my use of medical cannabis.

Patient Attestation:
_____ I have, or will, discuss my use of cannabis with my primary medical provider before I use it.
_____ I do not have medication abuse or drug abuse problems.
_____ I have not engaged in trafficking drugs or in drug diversion and will not do so.

<u>After your evaluation</u>, please initial the following:
_____ My questions pertaining to my recommendation or not receiving a recommendation today have been addressed
_____My physician has discussed with me the risks and benefits of medical cannabis
_____I have access to follow-up information for my provider.

Patient Signature: _____ Date: _____