Date:_______________

Patient Questionnaire

Personal Information:

Name. Marilyn Hulter___________________________ Date of Birth:_____________ Age_________ Gender: ▢Male ▢Female

Height:____________ Weight:____________ Email Address:____

Street Address:__________________________________ City:____________________ State:________ Zip:___________

Cell Phone:______________________ Home Phone:______________________Work Phone:_______________________

Do you currently have medical insurance? ▢Yes ▢No

If yes, what type: ▢Private ▢Medicare ▢Medical

Medical History:

CURRENT MEDICAL COMPLAINT: List the medical Problems for which you use or would like to use medical cannabis, include year of onset symptoms:

____

____

____

PRIMARY CARE PROVIDER: Please give the name & address of your healthcare provider (include chiropractor / psychologist /acupuncture, etc). Please also list the date you were last seen:

____

____

MEDICATIONS: List all of your medications (including prescription & over-the-counter)

____

____

____

List any medications you are allergic to:____

OTHER TREATMENTS: Check any other treatments you use for your condition

▢ Surgery ▢ Physical Therapy ▢ Chiropractic ▢ Massage

▢ Herbal Therapy ▢ Counseling ▢ Exercise ▢ Other:____

SURGICAL HISTORY: Please list the surgeries that you have had:

How do your symptoms interfere with your life? Check all that apply:
▢ Poor Sleep ▢Unable/limits my ability to work ▢Unable/limits exercise ▢interferes w/ personal relationships

▢ Increases stress/depressed mood ▢ Other:____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

▢ Asthma/Lung Disease ▢ Cancer ▢ HIV/AIDS .
▢ Diabetes ▢ Hepatitis ▢Epilepsy/Seizures .
▢ Stroke ▢ Liver Disease ▢ Kidney Disease . ▢
High Blood Pressure ▢ Heart Disease ▢ Sleep Disorders (sleep apnea, insomnia) .
▢ Substance Abuse ▢ Intestinal Disorders (IBS, Ulcers) ▢ Multiple Sclerosis .
▢ ADD/ADHD ▢ Psychiatric Disorders (depression, anxiety, etc.) .

Drug & Alcohol History:

DO YOU CURRENTLY USE:
Tobacco? ▢ Yes ▢ No If yes, number of cigarettes per day:______
Alcohol? ▢ Yes ▢ No . If yes, how many drink per day:_________

Cannabis History:

Have you ever been evaluated by another physician for medical

cannabis? ▢ Yes ▢ No If yes, list the name of the business, doctor, &

date seen ____

Female Patients Only:

Are you pregnant?

▢ Yes ▢ No

Are you currently breastfeeding?

▢ Yes ▢ No

Do you use cannabis to reduce or eliminate the use of any medications that have been prescribed for your medical condition? ▢ Yes ▢ No If yes, which medication(s) have you reduced or eliminated and why?

What is your preferred method of using cannabis? ▢ smoke ▢ vaporizer ▢ ingested ▢ topical

How often fo you use cannabis? ▢ everyday or almost everyday ▢ about 1-2 times per week
▢ more than once a month . ▢ a few times a year or less
▢ I have never tried marijuana

How does marijuana improve your symptoms? ____

ADDITIONAL INFO:
Do you have an open court case regarding cannabis? ▢ Yes ▢ No Are you currently on probation? ▢ Yes ▢ No

Please provide any additional information that may be relevant to the physician evaluation: ______________

I UNDERSTAND THAT the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested

information, it may adversely impact the physician’s ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Patient Signature:____ Date:________________