Northgate Professional Center
1985 Main Street, Suite 209
Springfield, Massachusetts 01103
Tel; 413-455-1081
Fax; 413-391-7489
www.marimedconsults.com

PATIENT MEDICAL HISTORY INTAKE FORM

Patient Information:

Name: _____

Date of Birth: _____ Gender: ____ Male ____ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Social Security Number (last 4)_____

WHERE DID YOU HEAR ABOUT US?_____

Have you brought medical records that document your medical condition?
_____ Yes

For what condition do you seek medical marijuana?

_____

Past Medical History:

____ AIDS (Acquired Immune Deficiency Syndrome)
____ ALS (Amyotrophic Lateral Sclerosis)
____ Alzheimer's disease
____ Arthritis:
____ Autoimmune condition
specify:
____ Back/neck injury/disease
specify:
____ Blood disorders
specify:
____ Brain disorders
____ Breast lesions
____ Cancer, specify:
____ Cachexia/Wasting Syndrome
____ Chrohn's disease
____ Chronic pain, specify:
____ Circulation (stroke, phlebitis, etc.)
____ Diabetes
____ Disc disease/injury:
____ Dystonia (spasms, tremors)
____ Ear problems
____tinnitus ____ hearing loss)
____ Eating disorder (anorexia, bulimia)
____ Endocrine problems (thyroid, hormones)
____ Fibromyalgia
____ Eating disorder
____: anorexia
____: bulimia
____ Epilepsy
____ Glaucoma
____ Hepatitis B
____ Heart disease
____ Hepatitis C
____ High blood pressure
____ HIV
____ Intestinal disorders
____: ulcers
____: colitis
____: IBS
____ Kidney disease
____: renal failure
____: cystitis
____ Liver disease
specify:
____ Lung disease (asthma, emphysema)
____ Mental disorders (anxiety, bipolar, depression, PTSD, schizophrenia)
____ Migraine headache
____ Multiple sclerosis
____ Persistent Muscle spasms
____ Osteoporosis
____ Parkinson's disease
____ Prostate disease
____ Rheumatic disease
____ Sciatica
____ Scoliosis
____ Seizures
____ Sleep disorders (insomnia, apnea)
____ Weight loss/gain

Review of Symptoms: Check (x) symptoms that are current and you have been treated for in the past year:

General:
___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Fever
___ Forgetfulness
___ Headache
___ Loss of sleep
___ Loss of weight
___ Nervousness
___ Numbness
___ Poor energy
___ Sweats

Gastrointestinal:
___ Abdominal pain
___ Appetite poor
___ Bloating
___ Bowel changes
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gas
___ Hemorrhoids
___ Indigestion
___ Nausea
___ Rectal bleeding
___ Stomach pain
___ Vomiting
___ Vomiting blood

Eye, Ear, Nose, Throat
___ Bleeding gums
___ Blurred vision
___ Crossed Eyes
___ Difficulty Swallowing
___ Double vision
___ Ear discharge
___ Earache
___ Hay fever
___ Hoarseness
___ Loss of hearing
___ Nosebleeds
___ Persistent cough
___ Ringing in ears
___ Sinus problems
___ Vision- flashes
___ Vision- Halos

Muscle/Joint/Bone:
(pain, weakness, numbness)
___ Arm ___ Hip
___ Back ___ Leg
___ Foot ___ Neck
___ Hand ___ Shoulder
___ Arthritis
___ Muscle cramps

Cardiovascular:
___ Cardiac palpitations
___ Chest pain or angina
___ High blood pressure
___ Irregular heart beat
___ Low blood pressure
___ Poor circulation
___ Rapid heart rate
___ Swelling of ankles
___ Varicose veins

Integumentary:
___ Bruise easily
___ Change in moles
___ Hives
___ Itching
___ Rash
___ Scars
___ Sore that won't heal

Psychiatric:
___ Anxiety
___ Depression
___ Disturbing feelings

Neurological:
___ Disturbance of speech
___ Dizziness, vertigo
___ Fainting

Respiratory:
___ Asthma
___ Bronchitis
___ Cough

___ Panic attack
___ Restlessness

___ Headache
___ Numbness

Neurological:
___ Seizures
___ Tingling
___ Weakness

___ Cyanosis
___ Painful breathing

Respiratory:
___ Pneumonia
___ Shortness of breath
___ Septum with blood
___ Tuberculosis

Endocrine:
___ Goiter
___ Hot/Cold Intolerance
___ Sexual dysfunction

Genito-Urinary:
___ Blood in urine
___ Frequent urination
___ Lack of bladder control
___ Menstrual Pain
___ Pregnancy

Hematological/ Lymphatic
___ Anemia
___ Bleeding tendency
___ Blood disorder

Surgical History: Please list any surgeries and date of such surgery:

None: ____ Surgery: _____

_____

Describe non-surgical treatments you have received/are receiving for your medical condition(s) for which you seek a recommendation of medical marijuana:

____ physical therapy ____ injections ____ chiropractic ____ acupuncture
____ pain specialist ____ talk therapist ____ social worker ____ psychiatrist
____ orthopedist ____ heart specialist ____ nerve specialist
____ oncologist ____ endocrinologist ____ other (specify): _____

Medications: List all medications currently taking (include dosage, frequency of use:

_____

_____

List any medications to which you are allergic: _____

Are you currently receiving treatment/taking medication for the condition for which you are being evaluated for medical marijuana certification?

____ Yes ____ No What Treatment?_____

Activities of Daily Living Assessment:

Please check if any of the following activities are substantially limited (i.e. pain/weakness/impaired strength or ability) by the medical condition for which you seek medical marijuana certification?

____ caring for myself	____ performing manual tasks	____ seeing
____ hearing	____ eating	____ sleeping
____ walking	____ standing	____ lifting
____ bending	____ speaking	____ breathing
____ learning	____ reading	____ concentrating
____ thinking	____ communicating	____ working
____ social interaction	____ operation of major bodily function	

____ other (please specify) _____

Marijuana History:

Do you presently use marijuana to treat your medical condition?
_____: Yes _____: No

Does marijuana provide relief for your symptoms (if yes, please describe, i.e. Lessens pain, improves sleep etc.):

_____
_____
_____

How effective is marijuana in treating the symptoms of your condition?

_____ Very effective _____ Effective _____ Somewhat effective

How does marijuana compare with your usual prescribed medicines in relieving your symptoms?

___ Prescribed medicines work much better ___ Marijuana works a little better than prescribed medicines
___ Prescribed medicines work a little better ___ Marijuana works much better than prescribed medicines
___ Prescribed medicines work no better ___ Marijuana and prescribed medicines work best together

Does use of marijuana modify your use of other drugs?: ____ Yes ____ No
Explain:

_____

Does use of marijuana modify your use of alcohol? ____ Yes ____ No
Explain:

_____

Frequency of marijuana use as medicine (i.e. daily, weekly, monthly etc.):

_____

Method of marijuana use as a medicine: ____ Vaporize ____ Ingest ____ Smoke
_____ Other

You understand that smoking is harmful to your lungs and is not medically advised? ____ Yes ____ No

Have you had any negative/adverse reaction from use of marijuana?
_____ No ____ Yes (if yes, please describe)_____

_____

Additional Information that you consider relevant to physicians evaluation:

_____

_____

My signature below attests to the fact that I have accurately and completely disclosed the requested information and indicates that I give permission to MariMed to verify my status as a patient in their office for the purpose of any certification that may be given with regard to the Humanitarian Medical Use of Marijuana. I do not waive any other patient and physician privacy rights under Federal HIPAA or Massachusetts State Laws.

Patient Signature: _____ Date: _____