Shore Wellness & MedSpa

Medical History and Intake Form
Medical Marijuana Certification

MMCC ID_____ **Recertification** □ **YES** □ **NO**

Name_____ Date of Birth_____

Social Security Number_____ Gender: □ Male □ Female

Address: Street: _____

City: _____ State_____ Zip Code_____

E-mail:_____

Home Phone: _____ Cell Phone: _____

Mother's Maiden Name: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____

Address: Street: _____

City: _____ State_____ Zip Code_____

Phone: _____

Primary medical condition for which Medical Marijuana is requested: □ Cachexia □ Anorexia
□ Wasting Syndrome □ Severe pain □ Severe Nausea □ Seizures □ Severe or Persistent Muscle Spasms
□ Glaucoma □ Post traumatic stress disorder (PTSD) □ Chronic pain

Please describe when this condition started_____

Other Medical Problems and/or Symptoms

1. _____
2. _____
3. _____

Please describe any previous tests **(**X-rays, CT scan, MRI, EMG etc**)** *or treatments* **(**Surgery, Injections, Medications and Therapy etc**)** *you have had for the treatment of this/these conditions***:**_____
_____
_____

Please describe what makes the symptoms worse:
□sitting □standing □rest □heat □cold □walking □exercise □other

Please describe what makes the symptoms better:
□sitting □standing □rest □heat □cold □walking □exercise □other

Past Medical History: *Please note if you have had any of the following Medical Problems*

□Arthritis	□Anxiety	□Chronic Pain	□Depression
□Diabetes	□Head Injury	□High Blood Pressure	□Heart Disease
□Hepatitis C	□Hyperthyroid	□Kidney Disease	□Liver Disease
□Multiple Sclerosis	□Osteoporosis	□Seizures	□Sleep Apnea
□Stroke	□Ulcers	□Gout	□Lupus
□Rheumatoid Arthritis		□Other _____	

Surgical History: *Please note if you had any surgeries and write date of each surgery*
□None □Surgery _____ Date: _____

Are you pregnant? □Yes □No □Unsure Date of last menstrual period _____

Allergies: □None Medication allergy: _____ Food_____

Family History: *Please write if anyone in your immediate family has any of the following illnesses:*

□None/don't know	□Alcoholism	□Arthritis	□Depression	□Cancer
□Multiple Sclerosis	□Drug Use	□Diabetes	□Bipolar disorder	□Heart Disease
□Parkinsonism	□Rheumatoid Arthritis	□Lupus	□Gout	□Other_____

Medications: Please list ALL medications/herbs you are taking (Use back of this page if needed).

Medications/Supplements	**Dosage**	**How long have you been taking this medication?**

Functional History: How do your symptoms affect your daily activities?_____
_____

Do you use any assisted devices? □No □Cane □Walker □Crutches □Wheelchair

Other comments or concerns you wish to address with the physician?_____
_____

Review of Systems Checklist: (please check all that apply to your current condition)

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck pain

Eyes-
□ Vision loss/changes
□ Glasses or Cataracts
□ Pain
□ Redness
□ Flashing lights
□ Cataracts
□ Glaucoma

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay Fever
□ Nosebleeds
□ Sinus Pain

Throat-
□ Bleeding
□ Dentures
□ Sore Tongue
□ Dry Mouth
□ Sore Throat
□ Hoarseness
□ Thrush
□ Non-healing Sores

Neck-
□ Lumps
□ Swollen Glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-Exam
□ Breast-feeding

Cardiovascular-
□ Chest Pain/Discomfort
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Sudden awakening from sleep with shortness of breath
□ Tightness
□ Swelling

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Trauma
□ Blood in urine
□ Incontinence
□ Change in urinary Strength

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□ Yellow skin or eyes

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Heat or cold intolerance
□ Sweating
□ Frequent Urination
□ Thirst

Psychiatric-
□ Nervousness
□ PTSD
□ Depression

Social History: Are you currently employed ? □Yes □No
What type of work _____
If you are no longer working why did you stop and do you expect to return to work? _____
_____

Are you on disability?(start date)_____ **On workmen's compensation**?(start date) _____

Are you? □ Married □ Single □ Divorced □ Widowed/Widower
Smoking History: □ No □ ex-smoker □ current
Drinking History: □ No □ ex-drinker □ current
Drug Use: □No □current □past □cocaine □marijuana □heroin □Other_____
Have you ever been addicted to prescription drugs □ Yes □ No

Psychiatric History: □ No **Have you ever seen a** □ psychiatrist □ psychologist □ social worker

Cannabis History: Are you currently using marijuana? □ Yes □ No
When did you start?_____ Frequency of Use : □ daily □ weekly □ monthly
Delivery System: □ pipe □ joint □ vaporizer □ tincture □ food
Have you had any adverse effects from cannabis? □ Yes □ No **If Yes:** □ anxiety □ insomnia □ depression □ paranoia □ other_____

Does cannabis provide relief from your medical symptoms/problem? □Yes □ No

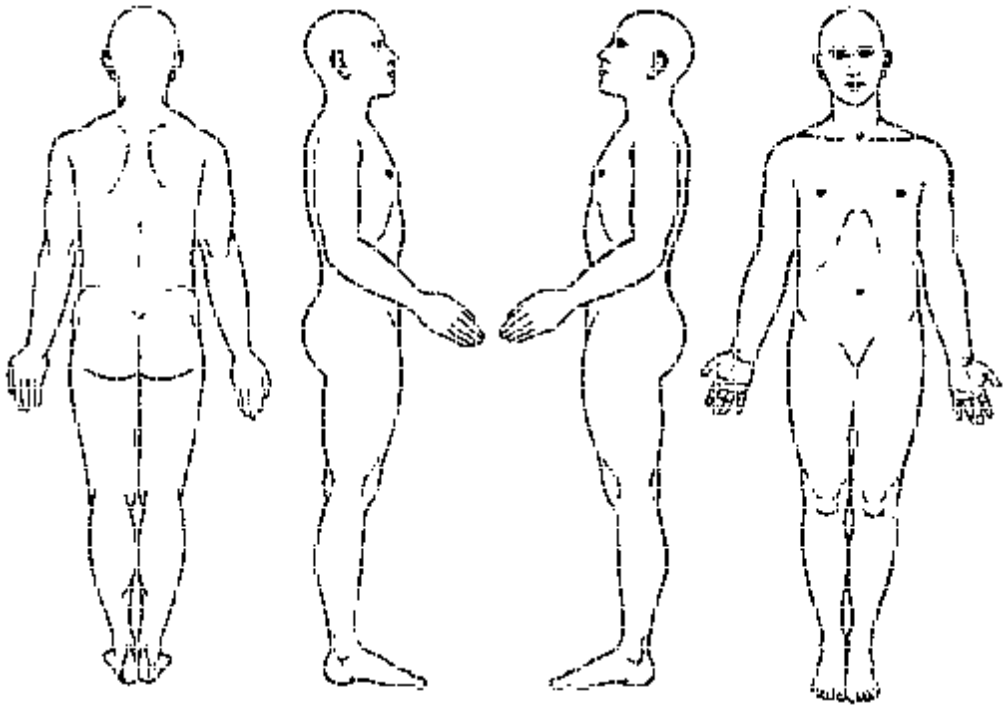
Pain Questionnaire:
Where is your worst pain?_____

How and when did your pain begin?_____
Does your pain radiate? To: □ R arm □L arm □R leg □L leg □other
Is the pain: □sharp □dull □burning □aching □stabbing □ shooting □throbbing □cramping □electric □intermittent □steady □superficial □deep □Other_____

Please rate your pain on a scale of 0-10 with 0 being no pain and 10 the worst pain imaginable.
0------1-------2------3------4------5-------6-------7-------8-------9--------10

How long has your pain been at this level?_____

On diagram below please mark the areas where you have pain-
Use the symbols to indicate where your pain is:
Moderate Pain = o Severe Pain = x Numbness = N Ache= A



L Back R **R Side** **L Side** **R Front L**

I believe that my physical and/or mental health will worsen, if I do not have medical marijuana available as self-medication. □ Agree □ Do not Agree

I consider my medical condition to be debilitating and that my condition is presently progressing to an extent that one or more major life activities (i.e., eating, sleeping, working, socializing) are substantially limited. □ Agree □ Do not Agree

Please initial all of the following:
I will not divert or provide medical cannabis to unauthorized individuals_____

I have found or I am interested in determining whether cannabis provides relief and improvement of my condition(s) or symptom(s) of my condition_____

I have discussed and have been informed by a healthcare provider of the potential benefits and risks of using cannabis and that it may **ADVERSELY** affect my health. If this occurs, I will stop using cannabis and will schedule an appointment with a physician to determine another form of treatment. I assume all risks of usage. _____

I agree **NOT TO DRIVE** a car or operate dangerous or heavy machinery while using marijuana.
_____

I understand that the **SIDE** EFFECTS associated with medical marijuana may include: dry mouth, nausea, headache, tremor, mystagmus, rapid heart rate, reduced muscle strength, decrease brain blood flow, decreased coordination, lung irritation, increase weight gain, altered body temp, anxiety, paranoia, confusion, aggressiveness, hallucinations, suicidal thoughts, sedation, altered perceptions, addictive behavior, reduced testicular size and testosterone, menstrual abnormalities, infertility, abnormal ova, fetal exposure in pregnancy. I also understand 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. _____

I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law. _____

I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulation concerning the safety and effectiveness of medical use of marijuana as a drug. I understand that the plant may contain unknown quantities of active ingredients, impurities and/or contaminants and that cannabis smoke may contain chemicals known as tars which may be harmful to my health. I understand that marijuana is still considered a Schedule 1 drug under federal regulations. _____

My signature below attests to the fact that I have read and have accurately completed this form to the best of my knowledge. All information regarding my medical condition and the records I am submitting is completely truthful and represents the medical condition for which I am seeking treatment. I voluntarily consent to this evaluation and understand that I am solely responsible for payment for services.

Patient's Signature_____ **Date** _____