# Shore Wellness & MedSpa

**New Patient 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

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**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?** | |
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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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***General- Head- Eyes*-**

**□** Weight loss or gain □ Headache□ Vision loss/changes

□ Fatigue □ Head injury □ Glasses or Cataracts

□ Fever or chills □ Neck pain □ Pain

□ Weakness □ Redness

□ Trouble sleeping □ Flashing lights

□ Hair and nail changes □ Cataracts

□ Glaucoma

***Nose- Throat- Neck-***

□ Stuffiness □ Bleeding □ Lumps

□ Discharge □ Dentures □ Swollen Glands

□ Itching □ Sore Tongue □ Pain

□ Hay Fever □ Dry Mouth □ Stiffness

□ Nosebleeds □ Sore Throat

□ Sinus Pain □ Hoarseness

□ Thrush

□ Non-healing Sores

***Breasts- Cardiovascular-***

□ Lumps □ Chest Pain/Discomfort □ Tightness

□ Pain □ Palpitations □ Swelling

□ Discharge □ Shortness of breath with activity

□ Self-Exam □ Difficulty breathing lying down

□ Breast-feeding □ Sudden awakening from sleep with shortness of breath

***Respiratory- Urinary- Gastrointestinal-***

□ Cough □ Frequency □ Swallowing difficulties

□ Sputum □ Urgency □ Heartburn

□ Coughing up blood □ Burning or pain □ Change in appetite

□ Shortness of breath □ Trauma □ Nausea

□ Wheezing □ Blood in urine □ Change in bowel habits

□ Painful breathing □ Incontinence □ Rectal bleeding

□ Change in urinary □ Constipation

Strength □ Diarrhea

□ Yellow skin or eyes

***Vascular-*** ***Musculoskeletal Neurologic-***

□ Calf pain with walking □ Muscle or joint pain □ Dizziness

□ Leg cramping □ Stiffness □ Fainting

□ Back pain □ Seizures

***Hematologic-*** □ Redness of joints □ Weakness

□ Ease of bruising □ Swelling of joints □ Numbness

□ Ease of bleeding □ Tingling

□ Tremor

***Endocrine-******Psychiatric-***

□ Heat or cold intolerance□ Nervousness

□ Sweating □ PTSD

□ Frequent Urination □ Depression

□ Thirst

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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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_