ADVANCED MEDICAL ASSOCIATES
P.O. Box 330
Lambertville, MI 48144

OHIO Patient Information Form

Name_____Date _____

Address_____

City_____State_____Zip_____

Cell Phone_____Work Phone_____Home Phone_____

D.O.B._____Age_____Email_____

Social Security #_____-____-_____

Chief Complaint: For which Patient is seeking use of Medical Marijuana

___ AIDS
___ Alzheimer's Disease
___ Amyotrophic Lateral Sclerosis
___ Cancer
___ Sickle Cell Anemia
___ Fibromyalgia
___ Traumatic Brain Injury
___ Multiple Sclerosis
___Spinal Cord Injury/Disease
___Inflammatory Bowel Disease
___Tourette's Syndrome
___Glaucoma
___Hepatitis C
___Crohn's disease
___Chronic Traumatic Encephalopathy
___Severe and Chronic Pain
___Intractable Pain
___Post Traumatic Stress Disorder
___Epilepsy or Seizure Disorder
___Ulcerative Colitis
___Parkinson's Disease
___ Positive Status for HIV

_____

Please describe the medical condition or complaint that you are seeking a recommendation for medical marijuana: (please include when you first noticed the symptoms and when you received the diagnosis)

_____

_____

_____

_____

_____

Is the condition active or in remission? _____
What makes your symptoms better? _____
What makes your symptoms worse? _____
What treatment have you done or tried to resolve this problem? _____

_____

Do you currently use cannabis to treat your current medical condition? YES _____ NO _____

If YES: How long have you been using cannabis? _____

Did you ever have any allergic reactions to cannabis? YES_____NO _____

Does it provide relief for your symptoms? (If yes, please describe. For example: less pain or nausea)

_____

How often do you use it (daily, weekly, monthly) _____

How much cannabis do you consume per treatment? _____

What method do you currently use to consume the cannabis - **Circle methods used:**

Ingest Vaporize Smoke

Which best describes how these symptoms collectively interfere with your life?

(Rate on a scale from 1-10, 1 being not at all and 10 being completely)

Work:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Sleep:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Mood:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Relationships:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Physical Activity:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Social History:

How often do you drink alcohol and how many drinks do you typically consume when you drink? (For example: Typically drink 6-10 drinks every weekend) _____

How often do you use any recreational drugs other than marijuana and what do you use? (Heroin, Cocaine, Ecstasy, Acid, Mushrooms, etc.) _____

How often do you smoke cigarettes and how many do you smoke each day? _____

Past Surgical History:

Please list any surgeries that you have had in the past. Include the reason, date, hospital and doctor who performed the surgery:

_____

_____

_____

_____

Past Medical History:

Name and contact of the Physician who treats you for the condition you are being evaluated for:

Name Address City State Zip

Phone/Fax

Approximate date (month/year) of the last time you visited your doctor: _____

Please list any medical condition that 1) a physician has evaluated you for 2) you were admitted to a hospital for or 3) you are currently being treated for : (For example: Arthritis, High Blood Pressure, Glaucoma, Migraine Headaches, Diabetes, Anxiety, Asthma, Hepatitis C)

_____

_____

_____

_____

Please list the medications that you are currently taking on a daily or occasional basis (please include over the counter medications such as Claritin): Include the dosage and frequency of use:

_____

_____

_____

_____

FEMALES: Currently using birth control? (Specify) _____

Are you allergic to any medications? YES____NO_____If yes, please list your drug allergies below:

_____

Employment History:

Are you employed: YES____ NO ___

What is your occupation?

_____

If you are NOT employed, what is your status?

___ Unemployed
___ Retired
___ Disabled
___ Workers Compensation
___ Student
___ Other

Family History:

Marital Status:

___ Single
___ Married
___ Divorced
___ Widowed
___ Domestic Partnership

Do you have children? YES___ NO___
Are you currently pregnant? YES ___ NO ___

In your family has there been a history of: (with Father, Mother, Brother, Sister, etc.)

___ Heart Disease _____
___ Arthritis _____
___ High Blood Pressure _____
___ Depression _____
___ Cancer _____
___ Alcohol Abuse _____
___ Drug Abuse _____
___ Diabetes _____

Patient Signature:

___ "I hereby certify that the above information regarding my medical history and condition is true and correct to the best of my knowledge. I understand that Advanced Medical Associates are only seeing me to evaluate my suitability under Ohio law for the use of medical marijuana as an additional treatment for my qualifying health problems. Advanced Medical Associates is not assuming responsibility for treatment of any healthcare problems or disorders. Nor are they responsible for any adverse reaction or conditions that may occur due to the use of medical marijuana. I understand that if I need care or treatment for any healthcare problem or disorder, other than the use of Medical Marijuana, it is my responsibility to seek care from another provider."

_____

Patient Signature **Date**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
For OHIO MEDICAL MARIJUANA CERTIFICATION

Patients Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

I request and authorize _____
(Doctor/Provider/Clinic Name & Address)
to release healthcare information of the patient named above to:

Advanced Medical Associates
PO Box 330
Lambertville, Mi. 48144
(734) 347-2127 or (419) 474-4700
Fax: (734) 847-4711
www.amamichigan/ohio.com

This request and authorization applies to healthcare information relating to the following treatment or condition. Check all that apply.

___ AIDS
___ Alzheimer's Disease
___ Amyotrophic Lateral Sclerosis
___ Cancer
___ Sickle Cell Anemia
___ Traumatic Brain Injury
___ Post-Traumatic Stress Disorder
___ Multiple Sclerosis
___ Spinal Cord Injury Disease
___ Inflammatory Bowel Disease
___ Tourette's Syndrome
___ Glaucoma
___ Hepatitis C
___ Crohn's Disease
___ Chronic Traumatic Encephalopathy
___ Severe and Chronic Pain
___ Intractable Pain
___ Epilepsy or Seizure Disorder
___ Ulcerative Colitis
___ Parkinson's Disease
___ Positive Status for HIV
___Fibromyalgia

I understand that:

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization.
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.

Patient Signature: _____ Date: _____
Print Name: _____

THIS AUTHORIZATION EXPIRES IN SIX MONTHS AFTER IT IS SIGNED.
A FAX/copy of this authorization shall be considered as valid as the original.