

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 _____

How did you hear about us? _____

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

- | | |
|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Traumatic Encephalopathy |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Severe and Chronic Pain |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Intractable Pain |
| <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy or Seizure Disorder |
| <input type="checkbox"/> Spinal Cord Injury/Disease | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> 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

My Signature Certifies I Have No Pending or Outstanding Legal Charges of Any Nature _____
Initials