ADVANCED INDIVIDUALIZED MEDICINE

# PATIENT MEDICAL HISTORY INTAKE FORM

**Patient Information:**

***Name:*** _____

***Date of Birth:*** _____ Gender: ___ Male ___ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

***Email:*** _____

***Social Security Number*** _____

WHERE DID YOU HEAR ABOUT US?_____

**For what condition(s) do you seek medical marijuana?**

**Please list all Doctors, name, address and phone that you have seen in the last 5 years for any condition that is related to your current health and request for medical marijuana:**

| Doctor Name | Address | Phone | Reason for visits |
|---|---|---|---|
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**Past Medical History:**

___ AIDS
___ ALS
___ Alzheimer's Disease
___ Intestinal Disorders
___ Ulcers
___ Colitis
___ Crohn's Disease
___ Cachexia/Wasting Syndrome
___ IBS

___ HIV
___ Auto-immune Disorder
___ Blood Disorders
___ Liver Disease
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ Anorexia
___ Bulimia

___ Weight Loss/Gain (lbs.: _____) Reason: _____
___ Brain Disorders
___ Back/Neck Injury/Disease - specify: _____
___ Disc Injury/Disease ___ Scoliosis
___ Osteoporosis ___ Sciatica
___ Kidney/Bladder Disease - specify: _____
___ Lung Disease - specify: _____
___ Mental Disorders - specify: _____
___ Bipolar ___ Depression ___ PTSD ___ Schizophrenia
___ Breast Lesions ___ Prostate Disease
___ Cancer - specify: _____
___ Chronic Pain - specify: _____
___ Fibromyalgia ___ Migraine Headaches
___ Circulation (stroke, phlebitis, etc.) ___ Diabetes
___ Dystonia (spasms, tremors) ___ Parkinson's Disease
___ Persistent Muscle Spasms ___ Seizures
___ Epilepsy ___ Multiple Sclerosis
___ Endocrine Problems (thyroid/hormones) – specify: _____
___ Rheumatic Disease ___ Asthma
___ Shortness of Breath ___ COPD
___ Hearing Loss ___ Tinnitus
___ Glaucoma ___ Vision Problems
___ Sleep Disorders (insomnia/apnea)
___ Heart Disease - specify: _____

**Surgical History: Please list any surgeries and date of such surgery:**
None: ___

| **Date of Surgery** | **Type of Surgery or Condition** |
|---|---|
| | |
| | |
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**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:**

| Medication | Dosage | Times per day | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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**List any medications to which you are allergic:**

| Medication | Type of Reaction |
|---|---|
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| | |

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

___ other (please specify) _____

Please detail what you hope to have as an outcome by utilizing medical marijuana:

**Marijuana History: Medical or otherwise**

**Do you presently use marijuana to treat your medical condition?**
**_____: Yes ____: No, if no skip to next section**

**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 AIM Naples to verify my status as a patient in their office for the purpose of any certification that may be given to me with regard to the medical use of marijuana.**

**Patient Signature: _____ Date: _____**

**Reviewed by_____ Date:_____**