



**Patient Information**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Sex: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Care Provider (PCP): \_\_\_\_\_

For what condition are you seeking to address with a Medical Cannabis Card?

\_\_\_\_\_

Do you have any food allergies, food sensitivities, or digestive issues? If so, please list below:

\_\_\_\_\_

Do you have any drug allergies? If so, please list below:

\_\_\_\_\_

Please list any current medications you are taking, and reason for use:

\_\_\_\_\_

---

Operations and/or Hospitalizations: (Please list surgeries and/or hospitalization reasons and dates)

---

Are you currently under any psychiatric care? If so, for what diagnosed conditions?

---

Are you currently on any antidepressant medications? \_\_\_\_\_ If so what kind? \_\_\_\_\_

If you are experiencing pain, on a scale of one to ten, with ten being the worst and one being no pain, how would you rate your current pain level? \_\_\_\_\_

Are you currently taking any opioid medications? \_\_\_\_\_ If so what kind? \_\_\_\_\_

Do you experience stress or anxiety on a daily basis? \_\_\_\_\_

How many hours of sleep do you get a night? \_\_\_\_\_

How many hours of exercise do you get a day / week? \_\_\_\_\_ / \_\_\_\_\_

Does your daily diet consist of fresh fruits and vegetables? \_\_\_\_\_

Do you smoke? \_\_\_\_\_

Do you consume alcohol daily? \_\_\_\_\_ Weekly? \_\_\_\_\_

How much water do you consume daily? \_\_\_\_\_ Tap or bottled \_\_\_\_\_

Do you have daily exposure to chemicals and fragrances in your home via cleaning supplies, or personal care items \_\_\_\_\_