

**Patient Information**

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

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

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address (City, State, Zip, **COUNTY**) ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 digestional 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 anti-depressant 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 opiod 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_