Patient Name _____ DOB _____ Date _____

What is the main medical reason that you are seeking medical marijuana today?

_____

When did you first notice the symptom?

_____

Is the symptom progressively getting worse?

_____

Where specifically is the problem located?

_____

What activities are difficult to perform (example: Sitting standing walking bending lying down)?

_____

Type of pain (dull sharp throbbing numbness aching shooting burning tingling cramps stiffness swelling other)?

_____

Rate the severity of pain (1 Mild to 10 Severe Pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatments have you had for this condition?

_____

Medication (Current or Past)

_____

Surgery

_____

Physical Therapy

_____

Other

_____

Health History (Please Circle)

Aids/HIV	Hepatitis	Cancer	Diabetes	Thyroid Disease
Liver Disease	Liver Disease	Kidney Disease	Glaucoma	Alcoholism
Chem-Dependency	Asthma	CODP	Emphysema	Eczema
Epilepsy/Seizures	Parkinson's disease	Multiple Sclerosis	ALS	Heart Disease
Hypertension	High Cholesterol	Stroke	Degenerative Disc Disease	
Herniated Disc	Rheumatoid Arthritis	Osteoarthritis	Degenerative Joint Disease	
Osteoporosis	Anxiety	Depression	Bi-Polar Disorder	
Schizophrenia	Anorexia/bulimia	Migraine Headaches	(IBS) Irritable Bowel Syndrome	
Fibromyalgia	Ulcers	Nausea/Vomiting	(GERD) Gastro esophageal reflux disease	
(SLE) Lupus	Ulcerative Colitis	Crohns Disease	PNS	
Menstrual Cramps	Interstitial Cystitis	Vulvodynia	Other _____	

Exercise	Work Activity	Habit _____
None	Sitting	Smoking Packs/Day _____
Moderate	Standing	Alcohol Drinks/Week _____
Daily	Light Labor	Caffeine Drinks Cups/Day _____
Heavy	Heavy Labor	High Stress Level High Stress Level _____

Past Family History _____

_____

Signature of Patient, Parent/Guardian or Representative _____ Date _____