OCEANSIDE 420 $100

New Patient Intake Form

Please fill out this form completely. No line should be left blank.

OFFICE USE ONLY

Name:_____ _____Patient #_____

Date of Birth:_____ Age:_____ Sex: M or F *(circle one)*

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Email:_____

CA Driver's License #:_____ or State ID Card #:_____

How did you hear about us?:_____

Your Medical Information

Health Habits: How much Alcohol do you consume each week?_____Tobacco?_____

Is there a family history of any medical problems? If yes, please explain:_____

Please list medications, both prescription and over- the- counter:_____

_____

Please listall allergies or side effects to medications:_____*(side effects may be one reason to use medical marijuana instead of pills)*

Your Last Medical Doctor or Clinic Visit

Name:_____ Phone:_____ Fax:_____

Date and Reason for the visit:_____

(If you DO NOT Remember your last doctor's visit, please write I DO NOT REMEMBER across this section)

Medical Symptoms/Diagnosis or Reason for Today's Evaluation

I,_____, am here to see the doctor today because I request an evaluation for a medical marijuana recommendation. I believe that the medicinal use of marijuana will relieve my symptoms. I have the following symptoms and/or diagnoses:

(Circle all that apply below:)

	Symptoms		Symptoms
	Anxiety / Stress / Insomnia/Rage		Nausea/ Vomiting /Abdominal Pain/ Chronic Stomach Upset
	Depressed feelings/Suicidal (Now)?		Difficulty Gaining Weight / Lack of Appetite
	Headaches		Chronic Cough
	Back Pain/Upper Mid Lower		Chest Pain (now)?/Shortness of Breath
	Neck Pain / TMJ Dysfunction		Skin Irritation
	Joint Pain:_____		Dizziness / Vision problems / Vertigo
	Muscle spasms:_____		Urinary problems
	Numbness or tingling in limbs		Erectile Dysfunction / Libido
	Menstrual Cramps / Hot Flashes		History of Addiction to:
	Diagnosis by your Doctor		**Diagnosis by your Doctor**
	AIDS / HIV/Wasting Syndrome		Asthma / COPD / Pulmonary Fibrosis
	ADD / ADHD (attention hyperactivity disorder)		Arthritis: Rheumatoid / Osteoarthritis / Psoriatic / Gout
	Bipolar/Depression / OCD		Cancer of:_____
	Anxiety/Panic disorder		Diabetes: Controlled / Uncontrolled HgbA1c?_____
	Schizophrenia / Schizoaffective Disorder		Restless Leg Syndrome
	PTSD (post traumatic stress disorder)		Epilepsy / Seizures / Traumatic Brain Injury / Stroke
	Heart Disease/High Blood Pressure/A-Fib		Hepatitis: B C (*circle one)*/ Cirrhosis
	Alzheimer's/Dementia		Kidney Disease/Chronic Interstitial Cystitis /Polycystic Kidney
	Migraine /Tension Headaches		Multiple Sclerosis / Cerebral Palsy / Parkinson's / ALS
	Stomach Ulcers/Ulcerative Colitis / GERD		Fibromyalgia / Lupus / Lyme Disease /Auto Immune Disorder
	Crohn's Disease/IBS/Cyclic Vomiting		Psoriasis / Eczema / Other:_____
	Menopause/ Polycystic Ovarian Syndrome		Neuropathy of:_____
	Thyroid Disease / Hashimoto's		Glaucoma/Intraocular Pressure/Macular Degeneration

Each Box Marked Above will be discussed at length with Dr. Shore. <u>It takes only ONE to qualify</u>.

For what symptoms are you seeking medical marijuana:

<u>(It is very important that every line is complete)</u>

1. What medical issue will you be seeing the doctor for today_____
2. What caused your problem:_____
3. How long have you had these symptoms:_____

Do you wish to be reminded of your renewal ? Y/N

Email:_____

Disclosures and Conditions

- Based on my beliefs and awareness of researched scientific evidence of the benefits of medical marijuana, I request that the doctor evaluate me for a recommendation to us medical marijuana. This would enable me to legally obtain medical marijuana to use for treatment of my medical conditions.
- If medical marijuana adversely affects my health, I will stop using medical marijuana. I assume all risk for the use of medical cannabis.
- I agree to obtain medical follow-up at my personal medical doctor's office, or obtain a personal doctor I have none now and to return this office for follow-up as recommended by the physician. I understand this is an obligation on my part for the continuity of care.
- I agree NOT TO DRIVE or operate heavy equipment while using medical marijuana.
- I DO NOT plan or intend to use my physician's recommendations for the purpose of illegally obtaining medical marijuana.
- I understand that by signing below, that Andrew Vanderveer, M.D. is a medical cannabis evaluator and NOT my primary care physician and will not provide services as such.
- I affirm that I have a serious medical condition that adversely affects my quality of life.
- I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
- It should be made absolutely clear that the physician, staff or representatives of this center are neither providing medical marijuana, nor are they encouraging any illegal activity in my obtaining or using medical marijuana.
- Furthermore, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold the physician, the staff or any agents of this center free and harmless of any liability resulting from the use of medical marijuana.

I have read, understood and affirm all of the above statements.

X_____ Date:_____

Please return this form to Khristie at the front window when you are finished. Thank you!