Date: _____

New Patient Medical History and Intake Form

Last Name: _____ First Name: _____ MI: _____

Primary Phone: _____Can we leave a voice and text message at this phone number? Yes / No

Email Address: _____Do we have permission to email you? Yes / No

DOB: _____ SS#:_____ Weight: _____lbs. Gender: Male / Female

Street Address: _____ City: _____ County: _____ Zip: ____

Emergency Contact:
Name: _____ Phone #: _____ Relationship: _____

Are you pregnant or planning pregnancy? Yes / No Last Menstrual Period _____

Are you in a substance abuse program? Yes / No If yes, please elaborate: _____

Please tell us about your chief complaint: _____

_____

When did your condition begin: _____

Is this condition a result of an injury? _____

Did you have any surgery associated with this condition? _____

Medical Records Release:

Who should we request records from to confirm your qualifying diagnosis?

Doctor Name	Address	Phone / Fax	Specialty

Please describe what makes the symptoms worse:

□sitting □standing □rest □heat □cold □walking □exercise □sex □touch □work □exercise/activities

□other: _____

Please describe what makes the symptoms better:

□sitting □standing □rest □heat □cold □walking □exercise □sex □touch □work □exercise/activities

□other:_____

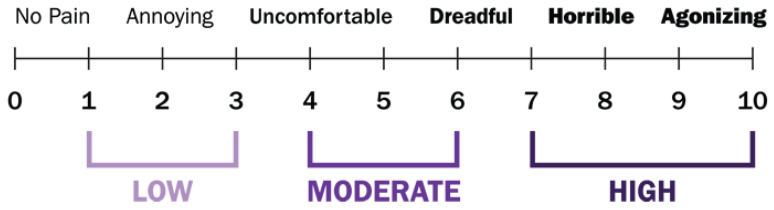
Please describe the quality of your pain if any:

□dull □aching □sharp □stabbing □burning □tingling □numbness □cramping □throbbing □stinging

□radiating _____ □other: _____

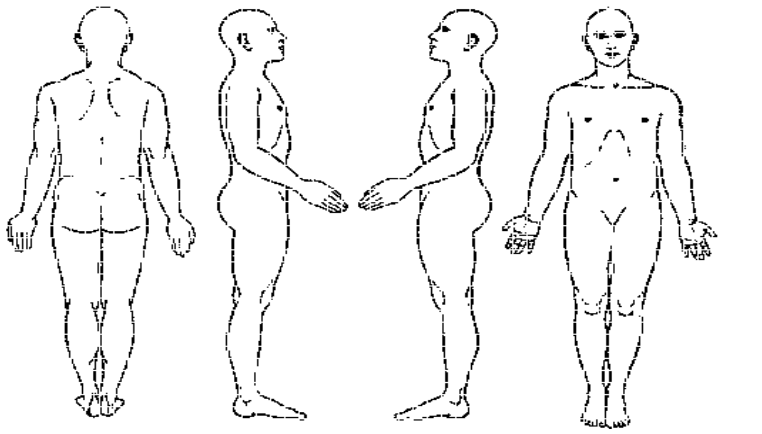
Would you describe your pain as: □localized □ general □persistent □recurring □chronic □relentless

On a scale of 0-10, how would you describe your pain today, while you are in our office_____ When it's at its worst? _____



On the diagram below, please indicate the areas in which you have chronic pain.
Please use the symbols to indicate where your pain is, and its intensity:

M= Moderate Pain S= Severe Pain N= Numbness A= Ache



Surgical History

Type of Surgery	Date	Who Performed	Associated Condition

Allergies

Allergen	Severity (mild, moderate, severe)	Reaction (ie; rash, hives, etc)

Medications:

Medication/Supplements/Herbs	Dosage	How long have you been taking this medication?

Past Medical History: *Please note if you have had any of the following Medical Illnesses / Problems*

□ Arthritis □ Anxiety Disorder □ Chronic Pain □ Depression
□ Diabetes □ Head Injury □ Heart Disease □ High Blood Pressure
□ Hepatitis C □ Hyperthyroid □ Kidney disease □ Liver disease
□ Multiple sclerosis □ Osteoporosis □ Seizures □ Sleep apnea
□ Stroke □ Ulcers □ Gout □ Lupus
□ Rheumatoid Arthritis □ Other _____

Family History: Please tell us if anyone in your immediate family has any of these illnesses:

□ Arthritis □ Alcoholism □ Depression □Diabetes □Cancer □ Multiple Sclerosis

□ Heart Disease □ Bi-polar Disorder □ Parkinson's Disease □Kidney Disease

Do you use any assistive devices?

□ Cane □ Walker □ Crutches □ Wheelchair □Prosthetic Limbs □ Other _____

Smoking History: Please check all that apply:

□ Non-smoker
□ Ex-smoker
□ Ex-user of moist powdered
□ Tobacco
□ Current non smoker but past smoking history unknown

□Light cigarette smoker (1-9 cigs/day)
□Moderate cigarette smoker (10-19 cigs/day)
□Heavy cigarette smoker (20-39 cigs/day)

□Very heavy cigarette smoker (40+ cigs/day)
□Cigar smoker
□Pipe smoker
□Chews tobacco
□Snuff user

Alcohol Use:

1. How often do you have a drink containing alcohol?
   □ Never □Monthly or less □2-4 times a month □2-3 times a week □4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?
   □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more
3. How often do you have 6 or more drinks on 1 occasion?
   □ Never □ Less than monthly □ Monthly or less □ Weekly □ Daily or almost daily

Drug Use: □never have used drugs □cocaine □marijuana □heroin □Other_____

Have you ever been addicted to any drug; prescription or recreational? □ Yes □ No

Have you ever seen a □ psychiatrist □ psychologist □ social worker

Cannabis History:

Are you currently using marijuana? □ Yes □ No

Frequency of Use: □ daily □ weekly □ monthly

Delivery System: □ pipe □ joint □ vaporizer □ tincture □ food/edible

Have you ever had any adverse effects from cannabis? □ no □yes

if yes, □ anxiety □ insomnia □ depression □ paranoia □ other _____

Does cannabis provide relief from your medical symptoms/problem? □yes □ no

Describe how Cannabis provides relief for your medical condition: _____

_____

_____

_____

My signature below attests to the fact that I have read and have accurately completed this form to the best of my knowledge. All information regarding my medical condition and the records I am submitting is completely truthful and represents the medical condition for which I am seeking treatment.

I am being evaluated for a physician's order for Medical Marijuana and I consent to this treatment by The Annex Healthcare, LLC. The physician will make this order based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical Marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of Medical Marijuana. I have been informed of and understand the following:

Patient's Signature _____ Date _____

Authorized Witness Signature _____ Date _____