

Pauline A. Wills, MD

Alternative Health and Biofeedback Medical Consultant

Name _____ Date _____

Height _____ Weight _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone _____ (circle: home / work / cell) E-mail _____

What is your occupation? _____

Do you have medical insurance? Yes / No If yes, what type/company? _____

Do you have a primary care physician? Yes / No If yes, please identify:

Name _____ Address _____ Phone _____

Specialist/ Consultant Name and Location 1) _____

Name and Location 2) _____

Name and Location 3) _____

What is/are the main medical problem(s) for which you seek a medical marijuana evaluation today? _____

When was the last time you saw your doctor/specialist about these complaints? _____

Which treatment modalities have you tried in treating your problems? (Please circle all that apply.)

medications herbs surgery therapeutic injections physical therapy osteopathic care
chiropractic care acupuncture homeopathy counseling other _____

Have you ever been hospitalized? Yes / No If yes, give details and dates: _____

Have you ever had any surgeries? Yes / No If yes, give details and dates: _____

Patient Signature _____

Doctor's initials _____

Are you taking any medications or herbs? Yes / No If yes, please list: _____

Do you have any allergies to any medications? Yes / No If yes, please identify: _____

Do you smoke tobacco? Yes / No If yes, how much? _____

Do you drink alcohol? Yes / No If yes, how much? _____

Do you currently use cannabis (marijuana) for your medical condition? Yes / No

If yes, how many times (circle one): a day / week / month? _____

If yes, what is/are your preferred method(s) of cannabis use?

Inhaled: vapor smoke (joint / pipe / bong)

Ingested: tea capsules butter/oil tincture baked goods other _____

Suppository: rectal vaginal

Topical: tincture cream/ointment poultice parabath DMSO spray

How does cannabis compare with other medications that you take for your medical problems?

Have you experienced any of the following symptoms? *(Please circle and initial at end of list.)*

Blood in stools Chest pain Constipation Cough Coughing blood Depression Diarrhea

Difficulty swallowing Easy bleeding or bruising Eye problems Fever Hearing problems

Heart palpitations Heartburn Loss of appetite Nervousness Pain with urination Rectal pain

Seizures Skin rashes Stomach pain Swollen ankles Toothache Vomiting *INITIALS* _____

Have you ever been exposed to asbestos, chemicals, poisons, or radiation (besides X-rays)? Yes / No

If yes, please explain: _____

Are there health/medical problems that occur frequently in your family? Yes / No

If yes, please explain: _____

Have you brought with you today medical records or other documents or items that support the medical condition(s) identified above? Y / N If no, why not and when will these be obtained?

Patient Signature _____

Doctor's initials _____