Living Rationally, Inc.

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PATIENT INTAKE QUESTIONNAIRE

To be considered for Medical Marijuana, all information must be provided:

Name _____ Date_____

DOB _____ SSN _____

Address _____

County _____ City _____, FL Zip Code _____

Fl Driver's License # _____

Phone # _____ is this a Cell Phone or Home Phone (please circle)

Email address _____ (needed for Medical Marijuana Use Registry)

Primary Care Physician _____ Phone Number _____

Reason for cannabis treatment (circle one or more):

Cancer	PTSD	Terminal illness	Migraine HA's
Epilepsy/Seizures	ALS	Severe Nausea	Neuropathy/Radiculopathy
Glaucoma	Crohn's Disease	Paraplegia/Quadriplegia	Chronic Nonmalignant Pain
Positive HIV Status	Parkinson's Disease	Muscle Spasms	Other debilitating illness (please explain):
AIDS	Multiple Sclerosis	Anxiety	

Allergy History:

	To What?	What Reaction Did You Have?
Please list any **Medication** Allergies:		

Please list ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm. If you already have a list, please attach.

	Name of Medication	Route Taken	Dosage	Frequency Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	Dementia	Hepatitis	Rheumatoid Arthritis
Alcoholism	Depression	Irritable Bowel Syndrome	Schizophrenia
Allergies, Seasonal	Diabetes: 1 or 2	Kidney Disease	Seizure Disorder
Anemia	Diverticulitis	Kidney Stones	Sleep Apnea
Anxiety	DVT (Blood Clot)	Lupus	Stroke
Arrhythmia (irregular heart beat)	GERD (Acid Reflux)	Liver Disease	Thyroid Disorder
Arthritis	Glaucoma	Macular Degeneration	Ulcerative Colitis
Asthma	Heart Disease	Neuropathy	Other (Please List):
Bipolar	Headaches	Osteopenia/Osteoporosis	
Bladder Problems/Incontinence	Heart Attack (MI)	Parkinson's Disease	_____
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer:	High Blood Pressure	Peptic Ulcer	_____
Crohn's Disease	High Cholesterol	Psoriasis	
COPD/ Emphysema	HIV	Pulmonary Embolism (PE)	_____

Other medical problems not listed above: _____

_____

Surgical History: Please list all prior surgeries and approximate dates performed:

_____

_____

SOCIAL / CULTURAL HISTORY:

Education Level: ❑ Elementary ❑ High School ❑ Vocational ❑ College ❑ Graduate / Professional

Are there any vision problems that affect your communication? ❑ Yes ❑ No

Are there any hearing problems that affect your communication? ❑ Yes ❑ No

Are there any limitations to understanding or following instructions (either written or verbal)? ❑ Yes ❑ No

Current Living Situation (Check all that apply):

❑ Single Family Household ❑ Multi-generational Household ❑ Homeless ❑ Shelter ❑ Skilled Nursing Facility

❑ Other: _____

Smoking/Tobacco Use: ❑ Current ❑ Past ❑ Never Type: _____ Amount per day: _____

Number of Years: _____

Alcohol: ❑ Current ❑ Past ❑ Never What type of Alcohol: _____ Drinks/week: _____

Recreational Drug Use: ❑ Current ❑ Past ❑ Never Type: _____

What route? Oral Snorting Injection Smoking Other: _____

FAMILY HISTORY (please circle answers):

FATHER:	Living: Age_____	Deceased: Age_____		
Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Schizophrenia
Arthritis	Dementia	Heart Disease	Migraines	Thyroid Disorder
Other: _____				
MOTHER:	Living: Age_____	Deceased: Age_____		
Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Schizophrenia
Arthritis	Dementia	Heart Disease	Migraines	Thyroid Disorder
Other: _____				
SIBLINGS:	Living: Age(s)_____	Deceased: Age(s)_____		
Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Schizophrenia
Arthritis	Dementia	Heart Disease	Migraines	Thyroid Disorder
Other: _____				

Patient Signature: _____ Date: _____