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Patient Information Form

Name____ Date ________________

Height _______ Weight ______ Date of Birth _________Age __ Marital Status _____ Sex M/F

Address: ________________________________City____________ State _____Zip____________

Phone _______________(circle: home / work / cell) Email ________________________________

What is your occupation? ____

How did you find out about us?____

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

Do you have a primary care provider? Yes / No If yes, please identify:
Name: ___________________ Address: ______________________Phone: _____________________

Specialist / Consultant name and Location: ____

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, please give details and dates: ________________

____

Patients Signature: _____________________________________ Doctors Initials _____________

Are you taking any prescription 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 / Tried it

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

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

Inhaled: [ ] vapor [ ] smoke (circle: joint / pipe / bong)
Ingested: [ ] tea [ ] capsules [ ] butter/oil [ ] tincture [ ] baked goods [ ] other _____________
Suppository: [ ] rectal [ ] vaginal
Topical: [ ] tincture [ ]cream/ointment [ ] poultice [ ] par bath [ ] DMSO [ ] spray

How does cannabis compare with the other medication that you take for your medical problems?_____

____

Do you or have you frequently experienced any of the following symptoms?
**** (Please check the box and initial at the end of this list.)****
[ ] Blood in stools [ ] Chest pain [ ] Constipation [ ] Cough
[ ] Coughing Blood [ ] Heart burn [ ] Eye problems [ ] Easy bleeding or bruising
[ ] Depression [ ] Loss of appetite [ ] Fever [ ] Pain with urination
[ ] Diarrhea [ ] Nervousness [ ] Hearing problems [ ] Rectal pain
[ ] Difficulty Swallowing [ ] Seizures [ ] Heart palpitations [ ] Skin rashes
[ ] Stomach pain [ ] Swollen ankles [ ] Toothache [ ] Vomiting
Initials ________

Are you currently on probation or parole? Yes / No

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? Yes / No if not, why not and when will these be obtained?

Female only: Date of last menstrual period __________________ Form of birth control______________

Patient Signature ____ Doctor's initials _____________

Disclosures and Conditions

1. BEACH MEDICAL CENTER PROVIDES MEDICAL EVALUATION AND CONSULTATIONS REGARDING RECOMMENDATIONS FOR MEDICAL CANNABIS OR MARIJUANA ONLY.
2. SERVICES FOR WHICH FEES MAY BE COLLECTED INCLUDE: MEDICAL CONSULTATIONS AND EVALUATIONS, COPYING OR DUPLICATING OF MEDICAL RECORDS.
3. PAYMENT OF FEES DOES NOT ENTITLE, ENSURE, OR WARRANT THAT (1) THE PATIENT WILL RECEIVE A MEDICAL CANNABIS RECOMENDATION OR THAT (2) ANY RECOMENDATION GIVEN WILL BE WRITTEN FOR AT LEAST TWELVE OR MORE.
4. INDICATIONS FOR THE MEDICINAL USE OF CANNABIS INCLUDE BUT ARE NOT LIMITED TO: CANCER, AIDS, GLAUCOMA, HEADACHES, ARTHRITIS, MULTIPLE SCLEROSIS, SEIZURES, ANOREXIA, SEVERE OR CHRONIC PAIN, CHRONIC NAUSEA, ANXIETY, DEPRESSION, MENSTRUAL CRAMPS, CHRONIC INSOMNIA, AND IBS.
5. ALL EVALUATIONS ARE DONE BY A CALIFORNIA LISCENSED PHYSICIAN AND INCLUDE (1) TAKING A MEDICAL HISTORY, (2) A PHYSICAL EXAM (EXCLUDING PRIVATE PARTS UNLESS REQUESTED BY PATIENT OR INDICATED BY PATIENT'S COMPLAINTS), AND (3) REVIEW OF PATIENT'S MEDICAL RECORDS - ALL PROSPECTIVE PATIENTS SHOULD BRING THEIR MEDICAL RECORDS AND ANY PRIOR OR CURRENTLY PRESCRIBED MEDICATIONS.

6. BEACH MEDICAL CENTER DOES NOT PROVIDE PRIMARY CARE, MEDICATION PRESCRIPTIONS, OR OTHER TREATMENTS. AS WARRANTED BY THE EVALUATION, ESPECIALLY IF THERE ARE NO PRIOR MEDICAL RECORDS AVAILABLE, THE PHYSICIAN MAY REFER THE PATIENT TO OTHER PROVIDERS AND OUTSIDE MEDICAL CARE FOR FURTHER EVALUATION AND TREATMENT.

7. SUBSEQUENT TO BEACH MEDICAL CENTER'S EVALUATION, ALL PATIENTS ARE INSTRUCTED TO FOLLOW UP WITH THEIR OWN PRIMARY CARE PHYSICIANS, MENTAL HEALTH AND OTHER HEALTH CARE PROVIDERS FOR CONTINUING CARE. LIKEWISE, WHERE RECOMENDATION IS GIVEN, PHYSICIAN MAY REQUIRE APPROPRIATE FOLLOW UP BE MADE.

8. ALL PATIENTS USING MEDICAL CANNABIS ARE ADVISED AGAINST DRIVING OR OPERATING HEAVY MACHINERY OR EQUIPMENT UNDER THE INFLUENCE OF CANNABIS.

9. SIDE EFFECTS ASSOCIATED WITH MEDICAL MARIJUANA USE INCLUDE: DRY MOUTH, HEADACHE, NAUSEA, TREMOR, NYSTAGMUS, RAPID HEART RATE, REDUCED MUSCLE STRENGTH, DECREASED BLOOD FLOW TO THE BRAIN, DECREASED COORDINATION, DECREASED LUNG CAPACITY/BRONCHOCONSTRICTION, INCREASED FOOD CONSUMPTION AND WEIGHT GAIN, ALTERED BODY TEMPERATURE, ANXIETY OR PANIC, PARANOIA, CONFUSION, AGGRESSIVENESS, HALLUCINATIONS, SUICIDAL IDEATION, SEDATION, ALTERED LIBIDO, ALTERATION IN TIME SPACE AND COLOR PERCEPTIONS, DEPERSONALIZATION, SHORT TERM MEMORY IMPAIRMENT, ADDICTIVE BEHAVIORS, ATTENTION, DECREASED VERBAL SKILLS, AMOTIVATIONAL SYNDROME, REDUCED TESTICULAR SIZE, DECREASED TESTOTERONE LEVELS, MENSTRUAL ABNORMALITIES, IMPOTENCE, ABNORMAL SPERM MORPHOLOGY / MOTILITY, INFERTILITY, GYNECOMASTIA, ABNORMAL OVA, FETAL EXPOSURE (IN PREGNANT USERS).

10. BEACH MEDICAL CENTER'S PHYSICIANS MAY DENY THE RECOMMENDATION IN APPROPRIATE CASES.

11. RECOMMENDATION IS VALID IN THE STATE OF CALIFORNIA ONLY.

I HEREBY CERTIFY THAT I HAVE READ AND ACKNOWLEDGE ALL OF THE ABOVE.

Patient Name: _________________________Signature: ___________________________Date: _______

MEDICAL MARIJUANA ACKNOWLEDGEMENT OF DISCLOSURE AND INFORMED CONSENT

**To be completed, signed, and dated by the patient"

Read each item below and initial in the space provided to indicate that you understand and agree to each item. Do not sign this agreement and do not use medical marijuana if you have questions about, or do not understand, the information you have received.

I, ____(patients Name), understand that medical marijuana is a medicine used in treating the suffering caused by serious and debilitating medical conditions. Serious and debilitating medical conditions include:

(1) Acquired immune deficiency syndrome (AIDS)
(2) Anorexia
(3) Arthritis
(4) Cachexia
(5) Cancer
(6) Chronic Pain
(7) Glaucoma
(8) Migraine
(9) Persistent muscle spasms, including but not limited to, spasms associated with multiple sclerosis
(10) Seizures, including but not limited to seizures not associated with epilepsy
(11) Severe nausea
(12)Any other chronic or persistent medical symptom that either:
    (A) Substantially limits the ability of the person to conduct one or more major life activity as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).
    (B) If not alleviated, may not cause serious harm to patients safety, physical or mental health

I understand that medical marijuana use for treatment of these conditions has not been approved by the Federal Drug Administration ("FDA")
Initials: ______ _

I have been advised and understand that the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities.
Initials: ________

Although smoking marijuana has not been linked to lung cancer, smoking marijuana can cause

respiratory harm such as bronchitis. Many researchers agree that marijuana smoke contains known carcinogens (chemicals that can cause cancer), and that smoking marijuana may increase the risk of respiratory diseases and cancers of the lungs, mouth, and tongue. I have been advised that cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to my health. Vaporizers may substantially reduce many of the potentially harmful smoke toxins that normally are present in marijuana smoke.
Initials:__________

I understand that side effects may occur while I am taking medical marijuana. These side effects have been explained to me. Side effects of medical marijuana can include, but are not limited to:

Headache **Nystagmus** **Rapid heart rate** **Reduced muscle strength**
Decreased blood flow to the brain **Decreased coordination**
Increased food consumption and weight gain **Altered body temperature**
anxiety or panic **Aggressiveness** **Paranoia** **Confusion** **Hallucinations**
Euphoria **Suicidal ideation** **Sedation** **Altered libido** **Cough**
Dizziness **Fatigue** **Hunger** **Nervousness**
Increased talkativeness **Inability to concentrate** **Dysphoria** **inattention**
Impotence **Decreased verbal skills** **Amotivational syndrome**
Reduced testicular size **Addictive behaviors** **Depersonalization**
Menstrual abnormalities **Fetal exposure** **Gynecomastia**
Abnormal ova **Short term memory impairment**
Alteration in time, space, and color perception **Decreased testosterone levels**
Tremor **Infertility** **Fatigue** **Tachycardia** **Nausea**
Abnormal sperm morphology/motility

Initials:_________

Marijuana varies in potency. The effects of marijuana can also vary with the delivery system. Estimating the proper marijuana dosage is very important. Symptoms of marijuana overdose include, but are not limited to:

Nausea Vomiting Hacking cough Disturbances to heart rhythms and numbness of the limbs

Initials:__________

For some patients, chronic marijuana over use can lead to laryngitis, bronchitis, and general apathy.

Initials: __________

Using marijuana may decrease reproduction function in men as well as women. Women who are trying to conceive, or who are pregnant or breast feeding should not use marijuana. Marijuana may increase the risk of leukemia in children whose mothers smoked marijuana during pregnancy. Marijuana may also increase risk of an aggressive form of testicular cancer in men.

Initials: ___________

I understand that some patients can become dependent on marijuana. This means they experience withdrawal symptoms when they stop using marijuana. Signs of withdrawal symptoms, while generally mild, can include:

Feelings of depression, sadness, or irritability Restlessness or mild agitation insomnia
Sleep disturbances Unusual tiredness Trouble concentrating Loss of appetite

Initials: __________

Although marijuana does not produce a specific psychosis, the possibility exists that it may exacerbate schizophrenia in persons predisposed to that disorder.

Initials:__________

I understand that using marijuana while under the influence of alcohol is not recommended.

Initials:__________

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities, and/or contaminants.

Initials:__________

I certify and declare under penalty of perjury that I have read and understood the information contained herein, and the information I have given is true, correct, and complete.

Patient name:____________________ Patient Signature: ________________________ Date: ________

Medical Marijuana Patient Agreement

I (Patient Name): ____________________agree to tell the attending physician if I have ever had symptoms of depression, been psychotic, attempted suicide, or had any other mental problem. I also agree to tell the attending physician if I have ever been prescribed or taken medicine for any of these problems.

Initials: _______ I understand that the attending physician does not suggest, nor condone, that I cease treatment of medications that stabilize my mental or physical condition.

Initials: _______ I affirm that I have a serious medical condition that adversely affects my quality of life. I have found, or am interested in finding, whether cannabis (medical marijuana) provides substantial relief and improvement in my condition.

Initials: ______ If I start taking medical marijuana, I agree to tell my attending physician if I experience any adverse symptoms (side effects), including but not limited to:

Start to feel sad or have crying spells Lose my appetite Have changes in my normal patterns
Become unusually tired Lose interest in my usual activities Become more irritable than usual

Initials:_______ I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and may contain unknown quantities of active ingredients, impurities, and/or contaminants. In requesting an approval or recommendation for the use of this plant as medication, I assume full responsibility for any and all risks of this action.

Initials: ______ I am advised that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me, and/or other individuals, as a result of my use of cannabis.

Initials: ______Some users develop a tolerance to marijuana. This means higher doses are required to achieve the same pain relief. If I think I may be developing a tolerance to marijuana, I will notify my attending physician.

Initials:_______Should respiratory problems or other ill effects be experienced in association with the use of medical marijuana, I agree to discontinue its use and report such problems or effects to the attending physician.

Initials:______ I understand that the attending physician, staff, and representatives of this practice are neither providing nor dispensing cannabis, nor are they encouraging any illegal activity in my obtaining medical marijuana.

Initials: ______I understand that the attending physician, in order to conduct an appropriate evaluation, must do a physical exam and take my prior medical history and family history. I decline examination of my private parts unless I feel it is relevant to my complaints.

Initials:_______ At this time, cannabis is an alternative or complementary treatment. I understand to receive a recommendation for cannabis use, I should have tried, or be willing to consider trying, at least one other recommended treatment from a medical provider. I have obtained or attempted to obtain medical records pertaining to my condition, or currently have medical records pertaining to my condition, and agree to be referred for further evaluation as the physician deems necessary.

Initials:_______ I certify that I do not have prior medical records or subscription items and if I do, I certify that I will furnish them to **Beach Medical Center**

Release of All Claims and Liability

I, the undersigned, hereby request a consultation by physician for the sole purposes of determining the appropriateness of medical cannabis treatment.

I, the undersigned, understand that there are no representations about the medical efficacy of cannabis.

I, the undersigned, further understand that the physician, staff, and representatives of this center are addressing the specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care provider. The physician is only rendering an opinion

regarding the therapeutic indication of the use of medical marijuana.

I, the undersigned, further understand that should I be given a recommendation for medical use of cannabis that I must be regularly followed up by a doctor and appear for a re-evaluation at a date specified by the physician.

Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician and his/her principles, agents and employees, free of, and harmless from, any responsibility and liability resulting from the use of cannabis. In case any claim or dispute arises, I agree to arbitrate such claims/disputes and I agree that California law will govern such claims/disputes. Further, if any of these clauses is deemed invalid, the other clauses will remain in full force and effect.

Patient Name:____ Date: _________________

Signature: ____

If you would like the staff at Beach Medical Center to remind you about your renewal 30 days prior to expiration please complete the following:

Today's Date:______________

Patient's Name:____

How would you like to be contacted?

[ ]Phone:____________________________________ [ ] Text [ ]Phone Call

[ ]Fax:_______________________________________

[ ]E-Mail:____________________________________

[ ]Other:____

Signature:____