The Wellness Point

PATIENT INFORMATION FORM
(Medical Marijuana)

Name:	Birth date:	Email:
Address:	Phone Numbers Home: Work:	Primary Care Provider: Referring Physician:
Reason for Visit:	Date of Onset:	Allergies: ❑ **None**

Condition (or conditions) you wish to treat:

- ❑ Amyotrophic Lateral Sclerosis
- ❑ Anxiety Disorders
- ❑ Autism
- ❑ Cancer
- ❑ Crohn's Disease
- ❑ Dyskinetic Disorders
- ❑ Damage to Spinal Cord
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ HIV/AIDS
- ❑ Huntington's Disease
- ❑ Inflammatory Bowel Disease
- ❑ Intractable Seizures
- ❑ Multiple Sclerosis
- ❑ Neurodegenerative Disorders
- ❑ Neuropathies
- ❑ Opiate Use Disorder
- ❑ Parkinson's Disease
- ❑ PTSD
- ❑ Severe Pain
- ❑ Sickle Cell Anemia
- ❑ Terminal Illness
- ❑ Tourette's Syndrome

Past Medical History (Check all that apply; Explain as necessary)

- ❑ Cancers ____________________
- ❑ High Blood Pressure ____________________
- ❑ Heart Disease ____________________
- ❑ Diabetes ____________________
- ❑ Stroke ____________________
- ❑ Arthritis ____________________
- ❑ Allergies ____________________
- ❑ Asthma ____________________
- ❑ Headaches ____________________
- ❑ Bowel Problems ____________________
- ❑ Gynecological Problems ____________________
- ❑ Anxiety ____________________
- ❑ Depression ____________________
- ❑ Other ____________________

Surgeries (Please list with dates): ____________________

Medications (Including vitamins, supplements, herbal therapies, over-the-counter medications, *etc.*)

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Habits (Please include type, amount, and frequency)

- ❑ Tobacco ____________________
- ❑ Alcohol ____________________
- ❑ Marijuana or Other Drugs ____________________
- ❑ Caffeine ____________________

Family History (Please indicate which relative)

- ❑ Cancer ____________________
- ❑ Heart Disease ____________________
- ❑ High Blood Pressure ____________________
- ❑ Stroke ____________________
- ❑ Addiction ____________________
- ❑ Allergies/Asthma ____________________
- ❑ Other ____________________

How did you hear about The Wellness Point? ____________________

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