PATIENT QUESTIONNAIRE

Personal Information

Date: _____

Name: _____ **Date of Birth:** _____
Age: _____ **Gender:** _____

Address: _____
City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email Address:**
_____

SSN: _____–_____–_____

Medical History

Current Medical Problems

Current Medications

Medication Allergies

Past Medical Conditions

Condition	**Yes**	**No**
Heart failure	☐	☐
Atrial fibrillation	☐	☐
Coronary disease or heart attack	☐	☐
Asthma / COPD	☐	☐
Organ transplant	☐	☐
Blood clot	☐	☐

Family History (Parents or Siblings)

Condition	Yes	No
Bipolar disorder	☐	☐
Schizophrenia	☐	☐
Psychosis	☐	☐

Cannabis History

How often do you use cannabis?

How much cannabis do you use?

How many times a day do you use cannabis?

Do you use cannabis to reduce or eliminate prescribed medications? ☐ Yes ☐ No

If yes, which medications have you reduced or eliminated?

Additional Information

Please provide any additional information that may be relevant to the physician evaluation:

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Patient Signature: _____

Date: _____

Print Name: _____

PATIENT ACKNOWLEDGEMENT

I understand that:

• The attending physician, staff, and/or representatives are neither providing, dispensing, nor encouraging me to obtain or use medical cannabis.

• The physician, staff, and representatives are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

• I acknowledge that I have not misrepresented any information herein. Any misrepresentation shall result in termination from the practice, cancellation of any or all appointments, and forfeiture of all fees or payments.

• I acknowledge that I am not recording any portion of my visit.

• I acknowledge that my continued approval for medical cannabis use and the state-issued card are contingent on reasonable adherence to the regimen given by my clinician. My card may be revoked at any time for inappropriate use as determined by my clinician.

AUTHORIZATION FOR RELEASE OF INFORMATION

• I hereby authorize the disclosure of my medical records and recommendations to my other health care providers, without limitation, in accordance with general medical practice and HIPAA.

• I hereby authorize disclosure to law enforcement of my patient status should I be arrested or detained related to my possession or use of cannabis for the purpose of justifying my possession of cannabis. I understand that this authorization is valid for the period during which the cannabis recommendation is in effect.

• I hereby authorize the disclosure of my medical records for any purpose consistent with Oklahoma law.

Patient Signature: _____

Date: _____