GREEN PALMS
HEALTH AND WELLNESS

Last Name :_____First Name : _____Middle I.:____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip:_____

Email Address: _____**Date of Birth**:_____/_____/19____

Social Security#_____-_____-_____ **WEIGHT:**_____

Height: _____ Sex: ▫ Male ▫ Female Married/ Divorce/Single/Significant Other

How did you hear about us? _____
For what condition do you seek Medical Marijuana?_____

Chief Complaints;
CurrentPainLevel (0~10) 0 1 2 3 4 5 6 7 8 9 10
Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10
Location:

How was the pain started ? ▫ Work related ▫ Auto accident ▫ Athletic injury ▫ Injury at home ▫ Other

Please, describe your pain
▫ Dull ▫ Aching ▫ Sharp ▫ Shooting ▫ Stabbing ▫ Throbbing
▫ Numbness ▫ Burning ▫Cramps
How often is your pain present? ▫ Occasional ▫ Frequent ▫ Constant
Worst time of day? ▫ Morning ▫ Afternoon ▫Evening ▫Night ▫All the time
Numbness anywhere? If so Where? ☐ Rt Leg ☐ Lt Leg ☐ Rt Arm ☐ Left Arm
"Pins and needles"?_____ Weakness?_____Swelling?_____
What makes symptoms worse/exacerbate?
▫ Walking ▫ Standing ▫ Lying down ▫ Sitting ▫ Bending forward
▫ Coughing ▫ Bowel movement ▫ Cold weather ▫ Hot weather
▫ Rainy day ▫ Lifting objects

What makes the symptoms better?

▫ Resting ▫ Massage ▫ Exercise ▫ Sitting ▫ Lying down ▫ TENS unit
▫ Physical therapy ▫ “Injections” ▫ Sleeping ▫ Bending backward ▫ Driving

Musculoskeletal ▫ Arthritis ▫ Rheumatoid arthritis ▫ Osteoarthritis ▫ Compression fracture ▫ Head injury ▫ Neck injury ▫ Lower back injury ▫ Spinal trauma ▫ Birth trauma ▫ Birth defect ▫ Lupus ▫Spina bifida ▫ Nerve injury ▫ Spinal cord injury ▫ Gout ▫ Osteoporosis ▫ Muscular dystrophy ▫ Muscle pain ▫ Scoliosis ▫Premenstrual depression ▫ Hot flashes Last mammogram:_____
▫ Prostate problems ▫ Difficulty starting urination

If applies: Chiropractor Name: _____
How often do you go?:_____

Sleeping : ▫ Well ▫ Poorly If Poorly, how often do you wake up at night?

Past Medical History

Heart _____
▫ Chest pain ▫ Chest pressure ▫ Shortness of breath ▫ Irregular heart beat ▫ Murmurs ▫ Coronary artery disease ▫ Hypertension ▫ Murmurs ▫Valvular disease ▫ Aneurysm ▫High cholesterol ▫Pacemaker ▫ Defibrillator ▫ Heart failure ▫ Angina

Lungs_____
▫ Allergies ▫ Emphysema ▫ Bronchitis ▫ TB ▫ Pneumonia ▫ Lung cancer ▫Asthma ▫ COPD

Gastrointestinal Kidney _____
▫ Weight loss ▫ Weight gain ▫ Fever ▫ Fatigue ▫ Loss of appetite ▫ Nausea ▫ Vomiting ▫ Pain in stomach ▫ Ulcers ▫ Hepatitis ▫ Painful urination ▫Frequent urination ▫ Bloody urine ▫ Kidney stone ▫ Incontinence ▫ Loss of libido ▫ Sexual difficulty ▫ Ulcer ▫ Reflux ▫ Gastritis ▫ Hepatitis ▫ Cancer ▫ Bleeding ▫ Diverticulosis ▫ Failure

Endocrine _____
▫ Hypothyroidism ▫ Hyperthyroidism ▫ Diabetes ▫ Parathyroid problems
▫ Dialysis (When)_____

Neuro _____
▫ Light headed/dizziness ▫ Fainting ▫ Weakness ▫ Stroke ▫ Tremor
▫ Seizure ▫Memory loss ▫ Vision problem ▫ Glaucoma ▫ Blurred vision
▫ Double vision ▫ Stroke ▫ Aneurysm ▫ Brain cancer ▫ Alzheimer's
▫ Disturbance of speech ▫ Dementia ▫ Seizures ▫ Parkinson's

OTHER symptoms or Diagnosis
▫ Ear pain ▫ Hearing loss ▫ Ear noises ▫ Nose bleed ▫ Sore throat ▫Coughing
▫ Hoarseness ▫ Difficulty breathing ▫ Asthma/Wheezing ▫ Constipation ▫ Diarrhea
▫ Heartburn ▫ Bloody stool ▫ Dental problems ▫ Anemia ▫ Fever ▫ Hay fever
▫Bleeding disorder ▫coughing up blood ▫ Easy bleeding ▫ Lymphoma/Leukemia
▫Frequent sinus problems ▫ Sickle cell disease ▫ Catch cold easily ▫ HIV/AIDS

Cancer _____

Date Diagnosed _____

Past Surgery History:

Current Medications : May attach your typed medication list if you have one.
1)
2)
3)
other:

Known Allergies: Please document/list any allergies you have including medications:

Psychotherapy if any: (Biofeedback, Meditation, Yoga, Swimming)
Psychiatric ▫ Depression ▫ Panic attacks ▫ OCD ▫ Manic ▫ Bipolar
▫ Suicidal attempts ▫ Anxiety ▫ Schizophrenia ▫Other
▫ Suicidal ideation ▫ Homicidal ▫Hallucination ▫ Psychosis ▫ Other

Significant Family History (Cancer, hypertension, diabetes, depression, back pain...)

Father side
Mother side
Siblings

- Social History
- **Tobacco use**? If so how often and how much?_____
  Alcohol use: If so how often and how much? _____

- **Marijuana use(circle one)**: Tried it only Used regularly Still use No longer use
- Positive or negative experience
- Did you experience Psychosis: ☐ Yes or No ☐

Activities of Daily Living Assessment: Please circle if any of the following activities are substantially limited (i.e. pain/weakness/impaired strength or ability) by the medical condition for which you seek medical marijuana certification?

☐ caring for myself ☐ performing manual tasks ☐ seeing ☐ hearing ☐ eating ☐ sleeping ☐ walking ☐ standing ☐ lifting ☐ bending ☐ speaking ☐ breathing ☐ learning ☐ reading ☐ concentrating ☐ thinking ☐ communicating ☐ working ☐ social interaction ☐ operation of major bodily function other (please specify)

_____

Use of recreational Drugs: ☐ Yes or ☐ no? (this is not submitted to insurance or other physicians, used to monitor the amount and safety during use of medical THC products)

Have you seen any other Physicians for a Medical Marijuana License in Florida?
Approved? ☐ Y or ☐ N Date: _____Dispensary used in the past: _____

If denied please explain why:

_____

My signature below attests to the fact that I have accurately and completely disclosed the requested information and indicates that I give permission Green Palms Health and Wellness, L.L.C. to verify my status as a patient in their office for the purpose of any certification that may be given with regard to the Medical Marijuana Use Department. I do not waive any other patient and physician privacy rights under Federal HIPAA or Florida State Laws.

Face to Face with Doctor, M.D. Signature: _____Date:_____

Patient Signature: _____Date:_____