KEVIN M. HOGAN, DC
Clinic Director

DEBRA HEMPHILL, ARNP
Advanced Registered Nurse Practitioner

ROBERT SAYRE, MD
Medical Director

First	Middle	Last
Name:		
Address:		
City/State/Zip:		
Phone number:	Email address:	
How did you hear about us?		
Current medical complaint:		
Are you **If yes**, what is the name of your primary care physician?		
Have you been evaluated for the use of medical marijuana by any other physician in the past? ☐ Yes ☐ No **If yes**, please give the name of the doctor, date seen, and condition for which cannabis was approved? _____ _____		
Have you been evaluated and denied a medical marijuana recommendation? ☐ Yes ☐ No **If yes**, explain:_____ _____ _____		
Female Pateints: Are you pregnant? ☐ Yes ☐ No Are you planning a pregnancy? ☐ Yes ☐ No		
Are you currently on parole/probation? ☐ Yes ☐ No		
Are you currently attending or have you attended any drug/substance abuse or rehabilitation program? ☐ Yes ☐ No **If yes,** what was the name of the program? _____ Date you entered program: _____ Reason for entering program: _____ _____		

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EAST HILL
MEDICAL GROUP

Have you ever been treated for symptoms of depression, been psychotic, attempted suicide, or had any other mental problems? ☐ Yes ☐ No
If yes, explain: _____
_____
Have you ever been prescribed or taken medication(s) for any of these problems?
☐ Yes ☐ No **If yes,** what medication(s)? _____
_____
If applicable, what is the name of your mental health physician:
_____

Do you currently smoke tobacco? ☐ Yes ☐ No
If yes, how often and how many per day? _____
Do you currently us marijuana? ☐ Yes ☐ No
If yes, how much do you use per week? _____
Are you currently taking any medications? ☐ Yes ☐ No
If yes, name the medication(s) and dosages below:
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any allergies to medications? ☐ Yes ☐ No
If yes, list medications: _____
_____
_____

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, give dates and details: _____
_____
_____

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EAST HILL
MEDICAL GROUP

Have you ever had surgery? ☐ Yes ☐ No
If yes, give dates and details: _____
_____
_____

Please indicate if you or your immediate family members have had any of the following problems:

Problem	**Self**		**Family**	
Asthma	☐ Yes	☐ No	☐ Mother	☐ Father
Stoke	☐ Yes	☐ No	☐ Mother	☐ Father
High Blood Pressure	☐ Yes	☐ No	☐ Mother	☐ Father
Tuberculosis	☐ Yes	☐ No	☐ Mother	☐ Father
Diabetes	☐ Yes	☐ No	☐ Mother	☐ Father
Cancer	☐ Yes	☐ No	☐ Mother	☐ Father
Hepatitis	☐ Yes	☐ No	☐ Mother	☐ Father
Kidney Disease	☐ Yes	☐ No	☐ Mother	☐ Father
Heart Disease	☐ Yes	☐ No	☐ Mother	☐ Father
Sinusitis	☐ Yes	☐ No	☐ Mother	☐ Father
Alcoholism	☐ Yes	☐ No	☐ Mother	☐ Father
Substance Abuse	☐ Yes	☐ No	☐ Mother	☐ Father

Please Indicate if you have had any of the following symptoms consistently:

Sleeplessness	☐ Yes	☐ No	Nausea	☐ Yes	☐ No
Stomach Pain	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Skin Rashes	☐ Yes	☐ No	Chronic Pain	☐ Yes	☐ No
Coughing	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Rectal Pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Fever	☐ Yes	☐ No
Heart Burn	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No
Loss of Appetite	☐ Yes	☐ No	Blood in Bowels	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No

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EAST HILL
MEDICAL GROUP

Informed Consent: Risks and Side Effects/Release of Liability

Name(printed): _____

Please read each item below and initial in the space provided to indicate that you understand the information regarding the risks and side effects of using cannabis. I agree to tell the attending physician if I do not understand any of the information provided.

_____I understand that the cultivation, possession, and use of cannabis, even for medical purposes, are currently illegal under federal law.

_____I understand that cannabis is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities, and/or contaminants.

_____Symptoms of a cannabis overdose include, but are not limited to, nausea, vomiting, numbness, irregular heartbeat, drowsiness, and anxiety.

_____In the event of an overdose, I am advised to lie down, relax, rest, and seek medical care.

_____There is little known regarding how cannabis may, or may not, react with other pharmaceutical or herbal medications.

_____Use of cannabis may result in higher dosages due to user's development of a tolerance to cannabis.

_____I understand that the use of cannabis may affect my coordination and cognition. I agree not to operate heavy machinery, drive, or engage in potentially hazardous activities while using cannabis.

_____I understand that it is against the law to drive a vehicle while using marijuana and that I can get a DUI for driving under the influence.

_____There is a possibility that cannabis may worsen schizophrenia in persons predisposed to that disorder.

_____I agree to stop using cannabis and inform the attending physician if I am experiencing any negative side effects that may be caused from my therapeutic use of cannabis.

EAST HILL
MEDICAL GROUP

Informed Consent: Risks and Side Effects/Release of Liability(continued)

_____There is the possibility of experiencing withdrawal symptoms when I stop using cannabis. I understand that these withdrawal symptoms can include, but are not limited to, depression, irritability, insomnia, loss of appetite, and tiredness.

_____I understand that cannabis is not recommended while under the influence of alcohol.

Patient's Release of Liability

_____I hereby state that I fully understand that potential risks and side effects related to the use of cannabis as described above.

_____Furthermore, in using therapeutically, I accept full responsibility in assuming the risks and side effects related to its use.

_____I agree that the attending physician and his/her principals, agents, and employees, shall not be held responsible for any harm resulting to me and/or other individuals as a result of my medical use of cannabis.

Patient Signature_____

Patient Initials_____ Date:_____

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FOR OFFICE USE ONLY

Patient Name: _____

Height: _____ Weight: _____ Blood Pressure: _____

Are the following normal?

Area	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Extremities			
Spine			
Neuro			
Other			

Treatment Notes:

_____
_____
_____
_____
_____
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_____
_____
_____
_____

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