MedPharm Iowa Dispensary – Patient Intake Form
Last updated: 06 NOV 2018

Patients, please fill out the following form. If you are a registered caregiver for a patient who has been certified for medical cannabis, please fill out the form using the patient's information.

Please note who is filling out this form by checking the appropriate box:

☐ ***Patient*** ☐ ***Caregiver***

Date: _____

Patient Contact Information

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Email: _____

Registered Caregiver Contact Information (if applicable)

Name: _____

Address: _____

City/State/ZIP: _____

Phone: _____

Email: _____

Certifying Provider Information

Provider Name: _____

Address: _____

Phone: _____

Emergency Contact Information

Contact Name: _____

Phone: _____

Relationship to Patient: _____

Medical History

Check here ☐ if the patient (or caregiver, if applicable) completed the Medical History section in consultation with the certifying provider.

Certifying Provider Additional Comments for Medical History:

1. **For which condition(s) has the patient received a certification for medical cannabis?** ***Please check all that apply.***

☐ Amyotrophic lateral sclerosis (ALS)	☐ Parkinson's disease (PD)
☐ Cancer	☐ Seizures
☐ Crohn's disease	☐ Terminal illness (please specify diagnosis): _____
☐ HIV/AIDS	☐ Ulcerative colitis
☐ Multiple sclerosis (MS)	☐ Untreatable pain (please specify diagnosis or type of pain): _____

2. **Does the patient have any condition above for which they have NOT received a certification for medical cannabis?**
   If yes, please list: _____
3. **Has the patient ever been treated for, or does the patient currently have any of the following?** ***Please check one option per row.***

Condition	**Yes**	**No**	**Notes**
Anxiety			
Arthritis			
Asthma			
Bipolar disorder			
Chronic obstructive pulmonary disease (COPD)			
Depression			
Diabetes			
Glaucoma			

Condition	Yes	No	Notes
Heart disease (including myocardial infarction, arrhythmia)			
Hepatitis or other liver disease			
Hypertension (high blood pressure)			
Hypotension (low blood pressure)			
Insomnia			
Kidney disease or kidney failure			
Schizophrenia or psychosis			
Seizures (epilepsy)			
Substance abuse			
Other medically significant condition: _____			

Additional Questions	Yes	No	N/A or Unknown
4. Does the patient have a heart condition or heart disease?			
a. If yes, is the patient's condition currently being managed by a healthcare provider?			
5. Is the patient prone to dizzy spells or fainting?			
6. Is the patient prone to falls or considered to be a fall risk?			
7. Is the patient currently pregnant, think they may be pregnant, or planning to become pregnant?			
8. Is the patient currently breastfeeding?			
9. Does the patient have a family history of schizophrenia or psychosis?			

10. **Has the patient been hospitalized within the past 5 years? If so, please list date and reason.**

11. **Has the patient had any surgeries within the past 5 years? If so, please list date and type.**

Medication History

Check here ☐ if the patient (or caregiver, if applicable) completed the Medication History section in consultation with the certifying provider.

Certifying Provider Additional Comments for Medication History:

1. **Please list ALL medications, supplements, nutraceuticals, vitamins, and herbal products the patient is currently taking.**

Product	Dose	Frequency	Condition Being Treated

Product	Dose	Frequency	Condition Being Treated

Additional Questions	Yes	No	N/A or Unknown
2. Is the patient currently taking Clobazam (Frisium, Urbanol, Onfi, Tapclob)?			
3. Is the patient currently taking Valproate (Convulex, Depakote, Epilim, Stavzor)?			
4. Has the patient ever experienced a severe adverse event related to a medication OR does the patient consider themselves to be medication sensitive?			
a. If yes, please list the medication(s): _____			
5. Please list any known allergies the patient has to medication(s) or food:			

Medical Cannabis History

Check here ☐ if the patient (or caregiver, if applicable) completed the Medical Cannabis History section in consultation with the certifying provider.

Certifying Provider Additional Comments for Medical Cannabis History:	
1. Patient's level of experience with cannabis:	☐ No experience ☐ Some experience ☐ Experienced user

2. **For which of the symptoms below is the patient seeking relief? *Check all that apply. Next to each item that is checked, please indicate the severity of the patient's symptoms using a scale of 1 through 10, (1 = not interfering with life at all and 10 = substantially interfering with life).***

☐ Chronic pain *(Severity:_____)*	☐ Muscle spasticity *(Severity:_____)*
☐ Nausea and/or vomiting *(Severity:_____)*	☐ Tremors *(Severity:_____)*
☐ Lack of appetite *(Severity:_____)*	☐ Insomnia *(Severity:_____)*
☐ Neuropathy *(Severity:_____)*	☐ Seizures *(Severity:_____)*
☐ Gastrointestinal pain *(Severity:_____)*	☐ Other: _____
☐ Muscle spasms *(Severity:_____)*	*(Severity:_____)*

3. **Is the patient currently experiencing any of the following symptoms NOT related to the condition for which they are certified?**

Condition	**Yes**	**No**	**Notes**
Anxiety			
Depression			
Fatigue			
Insomnia			
Increased intraocular pressure			
Joint pain			
Migraines			
Other (please specify): _____			

4. **If the patient has self-medicated with cannabis before, please list the method(s) of consumption, dose (if known), CBD:THC ratio (if known), and frequency.**

Additional Notes

Is there additional information that the patient would like us to know? If yes, please include that information here.

MedPharm Patient Consultant Notes

[To be filled out by the MedPharm Patient Consultant]