SAVING LIVES CENTER FAMILY CLINIC & URGENT CARE
3 HILLCREST DRIVE SUITE A101
FREDERICK, MD 21703
OFFICE (240)-575-9940 FAX (240)-575-9481

Patient Information Sheet

Date: _____

NAME: Last _____ **First** _____ **MI** _____

ADDRESS:
_____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH _____ **Gender: (circle one) Female Male**

RACE: (Please circle one) CAUCASIAN AFRICAN AMERICAN HISPANIC
OTHER_____
INDIAN NATIVE ANERICAN ASIAN

SOCIAL SECURITY Number (Adult Patient or Guarantor's SS#) _____

PHONE: CELL (_____) _____- _____ Home (_____) _____- _____

Email Address: _____

Emergency Phone Contact Name and phone number: _____

How did you hear about us? _____

I acknowledge that all information supplied by myself to Saving Lives Center Family Clinic & Urgent Care is true and correct: _____ (**Patient Initials**) (**telephone/tele-medicine consent obtained)**

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Patient Medical History Form for Evaluation of Medical Cannabis

1. **Medical diagnosis**: Check one or more

____ Severe Pain _____ Chronic Pain ____ Severe Nausea _____ Anorexia

____ Cachexia ____ Wasting Syndrome ____ Post Traumatic Stress Disorder

____ Severe and persistent muscle spasms ____ Glaucoma ____ Seizure Disorder

2. **What year did your condition begin**? _____

3. **Describe your condition(s)** (include symptoms, location, radiation, severity, what aggravates it, what helps it?

4. **Severity of symptoms**? Please rate on scale of 1 to 10 (10 being the worse)

5. Explain in detail how does it **interfere with your activities** (social, sleep, relationships, travel, exercise, walking, stairs, work, appetite, mood)?

6. What **treatments** have you had for your condition(s) and what were the **response?**

-Medications Tried for you conditions and response (past and current**):**

_____

_____

_____

_____

Physical therapy When? _____ How long? _____

Any relief with PT? Y/N/Some_____ block/rhizotomy

How many injections have you had for your pain condition? _____Who did your injections?

Please circle - (Orthopedist/Physiatrist-Pain specialist/Anesthesiologist/Rheumatologist)

List Procedures/Surgeries for your condition:

Procedures/Surgeries	Year

Psychological Counseling related to your condition? Y/N How long?

Acupuncture/Massage/Medication? (Please circle) How long?

What was the response?

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Past/Current Medical History

___ Number of alcoholic drinks per day: ____ per week: _____

___ History of opiate abuse? ____ Current opiate use? Y/N

___ History of chronic marijuana use? ____ Current tobacco use?

____ History of alcohol abuse? ____ History of drug addiction?

___ Coronary Heart Disease ____ Aortic Aneurysm

___ Stroke/TIA ____ Congestive Heart Failure

___ Peripheral Vascular Disease ____ COPD/Chronic Bronchitis/Emphysema

___ Asthma ____ Seizures

____ Atrial Fibrillation/Tachycardia ____ Cardiac Arrest

____ Depression (past or current) ____ Anxiety (past of current)

____ Bipolar Disorder ____ Psychosis/Hallucinations

____ Chronic Dizziness ____ Kidney or Liver disease

____ High blood pressure ____ Diabetes

____ Thyroid disease ____Eating disorders (current or in past)

____ Dry eyes or mouth ____ Dental problems

____ Possible pregnancy? Y/N When was last menstrual period? _____

____ Breast Feeding? Y/N ____ On a blood thinner

____ Headaches/Migraines ____Visual problems

____ Problems with Hearing ____Tinnitus or Vertigo

____ Chronic sinus problems ____ Dizziness or Syncope (loss of consciousness)

____ Chronic hoarseness ____ TMJ problem

____ Neck pain
____ Arthritis
____ GERD
____ Inflammatory Bowel Disease
____ Rheumatoid Arthritis
____ Kidney Stones
____ Incontinence of bowel/bladder
____ Chronic insomnia
____ Chronic Diarrhea
____ Blood in stool
____ Numbness/Tingling
____ Joint problems (pain/swelling)
____ chronic back pain
____ Irritable Bowel
____ Autoimmune Disease
____ Peripheral Vascular Disease/Claudication
____ BPH
____ Frequent Falls
____ Sleep Apnea/Restless legs
____ Chronic Constipation
____ History of cancer or current cancer
____ Weakness

All Hospitalizations (include psychiatric/eating disorder/medical):

Other medical Conditions not listed above:

Allergies to Medications:

Current Medications (include recreational drug use, prescription meds, herbs, vitamins, supplements):

Family History: (include history of drug addiction, alcohol abuse, psychiatric disorders, medical problems):

Mother: Alive/Deceased; Age____

Father: Alive/Deceased; Age ____

Siblings:

Social History:

Any current recreational drug use? Y/N Use of sleep meds? Y/N

Please list: _____

Smoker? Y/N When quit? _____ Amount Smoked_____ Packs/day

Alcohol Y/N Amount per week _____

Occupation: _____

Marital Status _____ single ____ divorced ____ married Children? ____ how many

Hobbies:

Pets:

Have you ever tried cannabis? Y/N If yes, what was the effect?

(paranoia/anxiety/pain relief/better sleep/relaxation/decreased muscle spasms/etc.).