

GreenStar Medical of Florida Patient Intake Form

General Information

Filling out this form does not guarantee an approval or recommendation for the use of medicinal cannabis.

Full Name	First Name	Middle Name	Last Name	DOB	
Address	Street	City	State	Zip	
Telephone			Phone#		
Email			Can we contact you by email?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we text you?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Text #		
Age			Occupation		

Medical Information

Current Medical Condition			
Are you currently under the care of a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the name of your primary care physician?	
Physician's Address			
Telephone			
If no, please provide us with the name of the physician or medical facility that you visited for your medical condition(s)			
Did you bring medical records/documentation today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what did you bring?	
Have you been evaluated for the use of medical marijuana by any other physician in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give name of doctor, date seen and condition for which cannabis was approved	
Have you been evaluated and denied a Medical Cannabis Recommendation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain	
Are you currently enrolled or attending school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify <input type="checkbox"/> HS <input type="checkbox"/> College <input type="checkbox"/> Other	
Do you have children?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what are your children's ages?	
Female Patients:			
Are you pregnant?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you planning a pregnancy?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you been arrested or charged with a crime in the last 2 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify		
Are you currently on parole/probation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently attending or have you attended any drug/substance abuse or rehabilitation program?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, then
Name of program?	Date entered	Reason for entering the program?
Have you ever been treated for symptoms of depression, been psychotic, attempted suicide or had any other mental problems?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain		
Have you ever been prescribed or taken medication for any of these problems?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what medications		
If applicable, what is the name of your mental health physician		
Do you currently smoke tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often and how many per day?
Do you currently use marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much do you use per week
Are you taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name the medication(s) and dosages below
Do you have any allergies to medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list medicine below
Have you ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give dates and details below
Dates	Details	
Have you ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give dates and details below
Dates	Details	

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

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Hepatitis Substance Abuse	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Cancer Kidney Disease
<input type="checkbox"/>	Sinusitis		

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

<input type="checkbox"/>	Sleeplessness	<input type="checkbox"/>	Skin Rashes
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	Coughing
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Rectal Pain
<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	Fever
<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	Blood in Bowels
<input type="checkbox"/>	Difficulty Swallowing		

Describe any other health problems that occur frequently with you or in your family

Signature

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal for a patient to film or record in this office with video camera, cell phone or any other recording device whether still image, video or audio. This is a direct violation of HIPAA regulations and Patient/Doctor confidentiality.

I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient Signature _____ Physicians Initials _____