

## Deland Medical Wellness Medical Cannabis Patient Intake Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip code: \_\_\_\_\_

County: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for seeking medical cannabis treatment: (Please circle one of the following)

Cancer

Epilepsy

Glaucoma

Positive Status for Human Immune Deficiency (HIV)

Acquired Immune Deficiency Syndrome (AIDS)

Post-Traumatic Stress Disorder

Amyotrophic Lateral Sclerosis

Crohn's Disease

Multiple Sclerosis

Parkinson's Disease

Multiple Sclerosis

Chronic Non-Malignant Pain

Medical Conditions of the same kind or class as comparable to those listed above

Terminal Condition diagnosed by a physician

Please list symptoms your experience, frequency, severity and duration.

Symptom	Frequency	Severity 1-10	Duration
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

Please list all treatments that you have tried, how long each treatment was and the outcomes of each treatment.

Treatment	Duration	Outcome
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Do you smoke cigarettes? yes or no If yes how much? \_\_\_\_\_  
and for how many years? \_\_\_\_\_

Do you drink alcohol? yes or no If yes how much? \_\_\_\_\_  
How often? \_\_\_\_\_

Do you use illegal drugs? yes or no If yes what types? \_\_\_\_\_  
How Much? \_\_\_\_\_ How Often? \_\_\_\_\_

Please list all you medical illness

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list all current medications, dosage and how many time a day.

Medication	Does	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

7. \_\_\_\_\_

**List all Allergies and Reactions**

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

**List all Surgeries and Dates**

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

## **MEDICAL LIABILITY RELEASE FORM**

Deland Medical Wellness Center policy for malpractice is as follows: As per Florida law we post on the wall in the reception area a notice that advises our patients that our physicians do not carry malpractice insurance. By signing this form, you agree not hold liable Deland Medical Wellness Center its partnering physicians, or staff legally responsible for injuring, harm or medical negligence resulting from treatment provided by Deland Medical Wellness Center. Patient's must complete this form to be eligible for any services with Deland Medical Wellness Center.

### **PLEASE PRINT ALL INFORMATION:**

Patients Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Telephone: \_\_\_\_\_

Patients Primary Care Physician: \_\_\_\_\_

**LIABILITY RELEASE:** I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her emergency care. I hereby release Deland Medical Wellness Center and its Partner Physicians or Staff from any legal, medical or financial responsibility.

**PATIENT /PARENT/GUARDIAN:** Please check one of the following and sign your name.

\_\_\_\_\_ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.

\_\_\_\_\_ I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(The above line is applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

# Medical Marijuana Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient, or the patient's parent or legal guardian if the patient is a minor, must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form.

This consent form contains three parts. Part A must be completed by all patients. Part B is only required for patients under the age of 18 with a diagnosed terminal condition who receive a certification for medical marijuana in a smokable form. Part C is the signature block and must be completed by all patients.

## **Part A: Must be completed for all medical marijuana patients**

### **a. The Federal Government's classification of marijuana as a Schedule I controlled substance.**

- \_\_\_\_\_ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Florida, which have modified their state laws to treat marijuana as a medicine.
- \_\_\_\_\_ When in the possession of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

### **b. The approval and oversight status of marijuana by the Food and Drug Administration.**

- \_\_\_\_\_ Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of marijuana for medical use is not subject to any federal standards, quality control, or other federal oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

### **c. The potential for addiction.**

- \_\_\_\_\_ Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Dr. \_\_\_\_\_ (name of qualified physician).

### **d. The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.**

- \_\_\_\_\_ The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of vehicular accident, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I

understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

**e. The potential side effects of medical marijuana use.**

\_\_\_\_\_ Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, may affect the production of sex hormones that lead to adverse effects, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

There is substantial evidence of a statistical association between long-term cannabis smoking and worsening respiratory symptoms and more frequent chronic bronchitis episodes. Smoking marijuana is associated with large airway inflammation, increased airway resistance, and lung hyperinflation. Smoking cannabis, much like smoking tobacco, can introduce levels of volatile chemicals and tar in the lungs that may raise concerns about the risk of cancer and lung disease.

\_\_\_\_\_ I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

\_\_\_\_\_ I agree to contact Dr. \_\_\_\_\_ if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Dr. \_\_\_\_\_ if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

**f. The risks, benefits, and drug interactions of marijuana.**

\_\_\_\_\_ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

\_\_\_\_\_ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. \_\_\_\_\_ immediately or go to the nearest emergency room.

\_\_\_\_\_ Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences.

I agree to follow the directions of Dr. \_\_\_\_\_ regarding the use of prescription and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

\_\_\_\_\_ Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact Dr. \_\_\_\_\_ immediately or go to the nearest emergency room if these symptoms occur.

\_\_\_\_\_ I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. \_\_\_\_\_ if I become pregnant, try to get pregnant, or will be breastfeeding.

**g. The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.**

\_\_\_\_\_ **Cancer**

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancers, including glioma.

There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. Due to a lack of recent, high quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy-induced nausea and vomiting.

There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer-associated anorexia-cachexia syndrome and anorexia nervosa.

\_\_\_\_\_ **Epilepsy**

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy.

Recent systematic reviews were unable to identify any randomized controlled trials evaluating the efficacy of cannabinoids for the treatment of epilepsy. Currently available clinical data therefore consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

\_\_\_\_\_ **Glaucoma**

- There is limited evidence that cannabinoids are an ineffective treatment for improving intraocular pressure associated with glaucoma.

Lower intraocular pressure is a key target for glaucoma treatments. Nonrandomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systemic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited. However, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular



pressure. To date, those studies showing positive effects have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

## Positive status for human immunodeficiency virus

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

## Acquired immune deficiency syndrome

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

## Post-traumatic stress disorder

- There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of posttraumatic stress disorder

A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived forms) and increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

## Amyotrophic lateral sclerosis

- There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis.

Two small studies investigated the effect of dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the sample sizes were small, the duration of the studies was short, and the dose of dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

## Crohn's disease

- There is insufficient evidence to support or refute the conclusion that dronabinol is an effective treatment for the symptoms of irritable bowel syndrome.

Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of inflammatory bowel diseases, including Crohn's disease.

## **Parkinson's disease**

- There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia.

Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson's disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

## **Multiple sclerosis**

- There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity.

Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

## **Medical conditions of same kind or class as or comparable to the above qualifying medical conditions**

- The qualifying physician has provided the patient or the patient's parent or legal guardian a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.
- The summary is attached to this informed consent as Addendum\_\_\_\_\_.

## **Terminal conditions diagnosed by a physician other than the qualified physician issuing the physician certification**

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.
- The summary is attached to this informed consent as Addendum\_\_\_\_\_.

## **Chronic nonmalignant pain**

- There is substantial evidence that cannabis is an effective treatment for chronic pain in adults.

The majority of studies on pain evaluated nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flower form provided by the National Institute on Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms.

While the use of cannabis for the treatment of pain is supported by well controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

**h. That the patient's de-identified health information contained in the physician certification and medical marijuana use registry may be used for research purposes.**

\_\_\_\_\_ The Department of Health submits a data set to the Consortium for Medical Marijuana Clinical Outcomes Research for each patient registered in the medical marijuana use registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient.

**PART B: Certification for medical marijuana in a smokable form for a patient under 18 with a diagnosed terminal condition.**

\_\_\_\_\_ Initial here if you are not a patient under 18 with a diagnosed terminal condition who will be receiving medical marijuana in a smokable form. After initialing here, complete part C.

If the patient is under 18, has a diagnosed terminal condition, and will be receiving medical marijuana in a smokable form, please review and initial the remainder of Part B before completing Part C.

**Respiratory Health**

\_\_\_\_\_ Exposures to tobacco smoke and household air pollution consistently ranks among the top risk factors not only for respiratory disease burden but also for the global burden of disease. Given the known relationships between tobacco smoking and multiple respiratory conditions, one could hypothesize that long-term cannabis smoking leads to similar deleterious effects of respiratory health, and some investigators agree that cannabis smoking may be even more harmful than that of tobacco smoking. Data collected from 15 volunteers suggest that smoking one cannabis joint can lead to four times the exposure to carbon monoxide and three to five times more tar deposition than smoking a single cigarette.

**Cognitive and Psychosocial Development**

\_\_\_\_\_ Researchers are still studying the long-term health effects of marijuana. Most people agree that marijuana use hurts adolescents more than adults. It is during the period of adolescence and young adulthood that the neural substrates that underlie the development of cognition are most active. Adolescence marks one of the most impressive stretches of neural and behavioral change with substantial a protracted development in terms of both brain structure and function. As a result, cannabis and other substance use during this period may incur relatively greater interference in neural, social, and academic functioning compared to late developmental periods.

- There is moderate evidence of a statistical association between acute cannabis use and impairment in the cognitive domains of learning, memory, and attention.
- There is limited evidence of a statistical association between sustain abstinence form cannabis use and impairments in the cognitive domains of learning, memory, and attention.
- There is limited evidence of a statistical association between cannabis use and impaired academic achievement and education outcomes.

- There is limited evidence of a statistical association between cannabis use and increased rates of unemployment and/or low income.
- There is limited evidence of a statistical association between cannabis use and impaired social functioning or engagement in developmentally appropriate social roles.

**\_\_\_\_\_ Addiction**

Marijuana, like some other brain-altering substances, can be addictive. Nearly one in 10 marijuana users will become addicted. Starting to use marijuana at a younger age can lead to a greater risk of developing a substance use disorder later in life. Adolescents who begin using marijuana before age 18 are four to seven times more likely than adults to develop a marijuana use disorder

**Part C: Must be completed for all medical marijuana patients**

\_\_\_\_\_ I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. \_\_\_\_\_ has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

Dr. \_\_\_\_\_ also informed me of the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that Dr. \_\_\_\_\_ informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits. Dr. \_\_\_\_\_ has explained the information in this consent form about the medical use of marijuana.

Patient (print name) \_\_\_\_\_

Patient signature or signature of the parent or legal guardian if the patient is a minor:

\_\_\_\_\_ Date \_\_\_\_\_

I have explained the information in this consent form about the medical use of marijuana to \_\_\_\_\_ (Print patient name).

Qualified physician signature:

\_\_\_\_\_ Date \_\_\_\_\_

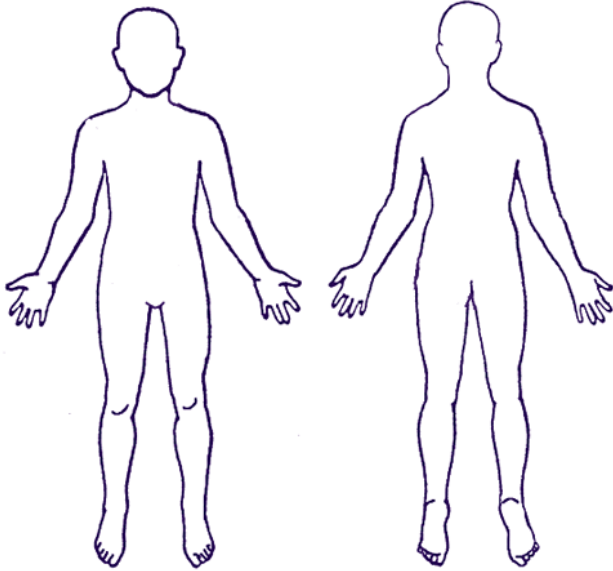
Witness:

\_\_\_\_\_ Date \_\_\_\_\_

# Health History

\_\_\_\_\_  
Patient Name

1. Please mark anywhere you may have pain and if it travels or radiates:



- XXXXX-Pain
- OOOOO-Numbness
- ////////-Aching
- \*\*\*\*\*-Pins & Needles

If you have pain, is it CONTINUOUS?

\_\_\_\_\_

2. Please mark any applications you have tried in the past.

Injections, joint \_\_\_\_\_ Injections, epidural \_\_\_\_\_ Acupuncture \_\_\_\_\_  
 Yoga \_\_\_\_\_ Chiropractor \_\_\_\_\_ Ultrasound \_\_\_\_\_ Massage \_\_\_\_\_ Electrical  
 Stimulation \_\_\_\_\_ Hot Pack \_\_\_\_\_ Pain Psychologist \_\_\_\_\_

3. Please check any positions that aggravate your pain.

Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Lying down \_\_\_\_\_  
 Bending waist \_\_\_\_\_ Bending, knees \_\_\_\_\_ Sleep w pillow \_\_\_\_\_  
 Walking \_\_\_\_\_ Bowel Movement \_\_\_\_\_

4. Do you have control of your bowels and bladder? YES NO

5. Please check any symptoms you have now or have had in the past.

**GENERAL**

\_\_\_\_\_ Chills  
 \_\_\_\_\_ Depression  
 \_\_\_\_\_ Dizziness  
 \_\_\_\_\_ Fainting  
 \_\_\_\_\_ Fever

**GENITO-URINARY**

\_\_\_\_\_ Blood in urine  
 \_\_\_\_\_ Frequent Urination  
 \_\_\_\_\_ Painful urination

**MUSCLE/BONE/JOINT**

**CARDIOVASCULAR**

\_\_\_\_\_ Chest Pain  
 \_\_\_\_\_ High Blood Pressure  
 \_\_\_\_\_ Irregular heart beat  
 \_\_\_\_\_ Poor circulation  
 \_\_\_\_\_ Rapid Heart Beat Low

<input type="checkbox"/> Forgetfulness	Pain, weakness numbness in:	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Headache	<input type="checkbox"/> Arms <input type="checkbox"/> Hips	<input type="checkbox"/> Ankles swelling
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Back <input type="checkbox"/> Legs	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Feet <input type="checkbox"/> Neck	
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	

7. Please check any symptoms you have had within the past 12 months.

**GASTROINTESTINAL**

Appetite poor  
 Bloating  
 Bowl changes  
 Constipation  
 Diarrhea  
 Excessive hunger  
 Excessive thirst  
 Gas  
 Hemorrhoids  
 Indigestion  
 Nausea  
 Rectal bleeding  
 Stomach Pain  
 Vomiting  
 Vomiting blood

**EAR, EYE, NOSE, THROAT**

Bleeding gums  
 Blurred vision  
 Crossed eyes  
 Difficulty swallowing  
 Double vision  
 Earache  
 Ear discharge  
 Hay fever  
 Hoarseness  
 Loss of hearing  
 Nosebleeds  
 Persistent Cough  
 Ringing in ears  
 Sinus problems  
 Vision – flashes or halos

**SKIN**

Bruise easily  
 Hives  
 Itching  
 Change in moles  
 Rash  
 Scars  
 non-healing sores

8. Please check any symptoms you have had within the past 12 months.

**MEN**

Breast lump  
 Erection difficulties  
 Lump in testicles  
 Penis discharge  
 sore on penis

**WOMEN**

Abnormal pap smear  
 Bleeding between period  
 Breast lump  
 Extreme menstrual pain  
 Hot flashes

Nipple discharge  
 Painful intercourse  
 Vaginal discharge  
 Last GYN exam

9. Please check any conditions you have had within the past 12 months.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Prostate problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> kidney disease	<input type="checkbox"/> Psych care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Mono	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Bleeding D/O	<input type="checkbox"/> Gout	<input type="checkbox"/> MRSA	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast lump	<input type="checkbox"/> heart disease	<input type="checkbox"/> MS	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal infect

\_\_\_ Chemical Dep      \_\_\_ Hi Cholesterol      \_\_\_ Polio      \_\_\_ Venereal Disease

10. Please list any medications or substances to which you have had allergic reactions.

11. List all medications you are currently taking.

<u>Medication</u>	<u>Strength</u>	<u>Quantity per day</u>
_____	_____	_____
_____	_____	_____

12. Do you have a history of substance abuse?      YES      NO      When

13. Please check if you use any of the substances listed and how often.

Heroin _____	How often _____	How much _____
Opioid Pain Pills _____	How often _____	How much _____
Benzos _____	How often _____	How Much _____
Alcohol _____	How often _____	How much _____
Caffeine _____	How often _____	How much _____
Cocaine _____	How often _____	How much _____
THC _____	How often _____	How much _____
Tobacco _____	How often _____	How much _____

14. Why are you seeking care from Deland Medical Wellness Center LLC?

\_\_\_\_\_

15. Please list your immediate blood relatives and, if deceased, please note cause of death.

	<u>Living/Deceased</u>	<u>Age</u>	<u>Cause of Death</u>
Father	_____	___	_____
Mother	_____	___	_____
Brothers	_____	___	_____
Sisters	_____	___	_____

16. Have you been to any detox treatment centers or addiction/drug counseling for your addiction? If so, please explain when and where and for what exactly.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the information I have provided on this health history questionnaire is correct to the best of my knowledge. I will not hold my doctor, Deland Medical Wellness Center, its affiliates, officers, directors, employees and contractors responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



DELAND MEDICAL  
WELLNESS CENTER