ACCESS 420 MEDICAL Patient Questionnaire

Personal Information **Date**_____

Name_____Date of Birth_____Age____

Height_____Weight_____Gender: Male / Female

Address_____City_____State/Zip_____

Home Phone_____ Cell Phone_____Work Phone_____

Email
Address_____

Medical History

Current medical complaint: (List the medical problems for which you use or would like to use medical marijuana; please provide details. Let us know if you need more space.)

_____

_____

_____

Who takes care of you for your medical problems (doctor, chiropractor, acupuncturist, massage therapist, psychologist or counselor, etc.)? Please give the name and tell us when you were last seen.

_____

_____

_____

Medications: List all of your medications (include prescription, herb, and over-the-counter).

_____

_____

List any medication you are allergic to:_____

Other treatments: Check any other treatments you use for your condition:

____surgery ____physical therapy ____chiropractic ____massage ____herbal therapy
____counseling ____exercise ____other_____

Medical History (continued)

Do you have or have you ever had any of the following medical problems?

____Asthma/Lung Disease
____HIV/AIDS
____Hepatitis
____Stroke
____Kidney Disease
____Heart Disease
____Substance Abuse
____Multiple Sclerosis
____ADD/ADHD
____Cancer
____Diabetes
____Epilepsy/Seizures
____Liver Disease
____High Blood Pressure
____Sleep Disorders (sleep apnea, insomnia)
____Intestinal Disorders (IBS, ulcers)
____Mental health problems

Female Patients Only:

Are you pregnant? Yes/No Are you currently breastfeeding? Yes/No

Surgical History

Please list the surgeries that you have had:

_____

_____

_____

Drug and Alcohol History

Do you currently use:
Tobacco Yes/No number of cigarettes per day _____
Alcohol Yes/No number of drinks per week _____

Other substance use history:
_____ Cocaine/Meth
_____ Opiates/Prescription opiates/heroin/methadone
_____ Hallucinogens/ecstasy/LSD/mushrooms
_____ None

Would you like help quitting? Yes / No / NA

Medical History (continued)

Marijuana History (continued)

Have you been evaluated by another physician for medical marijuana? Yes/No
If yes, where and when:

Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition? Yes/No

If yes, which medication have you reduced or eliminated and why?

How often do you use marijuana?
____ everyday or almost every day
____ about 1-2 times per week
____ more than once a month

What is your preferred method of using marijuana?
____ smoke ____vaporizer ____ingested ____topical

How effective is marijuana for your medical problem?
____ very effective ____ effective ____ only somewhat effective

How else does marijuana affect you?

Do you regularly experience unpleasant / unwanted side effects of marijuana? Yes / No
If yes, please explain:

_____

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

_____ _____
Patient Signature Date

ACCESS 420 MEDICAL SERVICES
IMPORTANT PATIENT ACKNOWLEDGEMENTS

By signing this page, you are acknowledging that:

The physician, staff, and/or representatives of Access 420 Medical Services are neither providing nor dispensing medical marijuana.

The Access 420 Medical Services physician will NOT be providing or discussing information regarding dispensary, co-op, delivery service, or any other way to obtain marijuana.

The physician, staff, and representatives of Access 420 Medical Services are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

My initial fee allows me free unlimited visits for one (1) calendar year.

Should an approval be made for my medical use of cannabis, there is a renewal date specified by the physician. It is my responsibility to see the physician to re-evaluate possible continuance of cannabis use beyond the term of the approval.

I am a resident of California and have not misrepresented any information to Access 420 Medical Services.

I am not an agent of law enforcement, state, or federal government here for the purpose of investigation or entrapment.

I am not recording any portion of my visit with Access 420 Medical Services nor do I possess any recording equipment. I understand Access 420 Medical Services does not approve such action.

Patient Signature: _____ Date: _____

ACCESS 420 MEDICAL SERVICES INFORMED CONSENT

By signing below, you acknowledge that you have been informed of and understand the following:

I am being evaluated for a physician's recommendation for marijuana. The physician will make this determination based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I must be a California resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under California's Compassionate Use Act of 1996 (Health & Safety Code Section 11362.5).

Marijuana has not yet been approved by the Food and Drug Administration. Therefore, marijuana sold for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The use of marijuana can affect coordination, motor skills, and cognition, i.e., the ability to think, judge, reason and act. While using marijuana, I should not drive, operate heavy machinery, or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

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, 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 marijuana may cause me to talk or eat in excess, alter my perception of time and space, and impair my judgment.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

I understand that I may contact Access 420 Medical Services if I experience any of these side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or

(continued)

experience crying spells. I will also contact Access 420 Medical Services 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.

Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema, and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth, and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician. The physician will inform me of alternatives to smoking marijuana.

The risk, benefits, and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

Individuals may develop a tolerance to, and/or dependence on, 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 Access 420 Medical Services. 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 may contact Access 420 Medical Services, contact my primary care physician, or dial 911 or go to the nearest emergency room.

If Access 420 Medical Services subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may be revoked. I agree to promptly meet with Access 420 Medical Services and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

I will have 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.

Patient Signature: _____ Date: _____

ACCESS 420 MEDICAL SERVICES

Acknowledgement
of
Notice of Privacy Practices

I hereby acknowledge that I have been made aware of the Notice of Privacy Practices for Access 420 Medical Services. I understand that I may obtain additional copies upon request, as described in the Notice.

Our office has our Privacy Policy posted in the waiting room. You can also find our privacy policy online at www.access420medical.com.

This Acknowledgement will be filed with my records.

Patient Name (print): _____

Patient Signature: _____ Date: _____

ACCESS 420 MEDICAL SERVICES

Authorization for Release of Information

Please initial next to each entry to which you agree:

Initials

_____ I hereby authorize Access 420 Medical Services to disclose and verify that I am a patient of Access 420 Medical Services to a marijuana dispensary or co-op for the purpose of obtaining marijuana. I understand that this authorization is valid only for the period of time for which the recommendation for marijuana, issued by my Access 420 Medical Services physician, is valid.

_____ I hereby authorize Access 420 Medical Services to disclose and verify my status as a patient of Access 420 Medical Services to law enforcement should I be arrested or detained related to my possession of use of marijuana. I understand that Access 420 Medical Services will only provide verification of my patient status for the purpose of providing proof to justify my possession of marijuana. I understand that this authorization is valid only for the period of time for which the recommendation for marijuana, issued by my Access 420 Medical Services physician, is valid.

Patient Name (print): _____

Patient Signature: _____ Date: _____

VOLUNTARY STATE ID CARD PROGRAM (OPTIONAL)

Information

In addition to our physician's recommendation letter, you may apply for a Medical Marijuana Identification Card in the county in which you reside. This Identification Card serves as further evidence that you are authorized to possess and use medical marijuana as permitted under California law (Health & Safety Code section 11362.5 et seq). State law does not require you to obtain an Identification Card. For more information on the Identification Card and registration program, you may go to the California Department of Public Health website at http://www.cdph.ca.gov/programs/MMP or call the Department at (916) 552-8600.

If you do wish to obtain a State ID Card, please complete the following:

Authorization for Release of Information

The undersigned hereby authorizes Access 420 Medical Services and its authorized agents to release medical information to the California Department of Public Health and/or _____ (insert the name of the County in which you reside) County Health Department as may be necessary for the issuance of a Medical Marijuana Identification Card and registration in the State database of authorized Identification Card holders. Except as permitted by State law governing access to the Statewide registry of authorized Identification Card holders, information so disclosed may not be further disclosed or used by the recipient for any other purpose without my authorization. This authorization shall expire one (1) year from the date set forth below.

Patient Name (print): _____

Patient Signature: _____ Date: _____

I acknowledge that I have been advised that I have a right to receive a copy of this authorization.

_____ (initials).