

ADVANCED MEDICAL ASSOCIATES

P.O. Box 330

Lambertville, MI 48144

MICHIGAN Patient Information Form

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

D.O.B. _____ Age _____ Email _____

Social Security # _____ - _____ - _____

Chief Complaint: For which Patient is seeking use of Medical Marijuana

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Agitation of Alzheimer's disease | <input type="checkbox"/> Nail patella |
| <input type="checkbox"/> Cachexia or Wasting Syndrome | <input type="checkbox"/> Severe and Chronic Pain |
| <input type="checkbox"/> Severe Nausea | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Severe and Persistent Muscle Spasms | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> Autism |

Please describe the medical condition or complaint that you are seeking a recommendation for medical marijuana: (please include when you first noticed the symptoms and when you received the diagnosis)

Is the condition active or in remission? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What treatment have you done or tried to resolve this problem? _____

NO _____

Do you currently use cannabis to treat your current medical condition? YES _____

If YES: How long have you been using cannabis? _____

Did you ever have any allergic reactions to cannabis? YES _____ NO _____

Does it provide relief for your symptoms? (If yes, please describe. For example: less pain or nausea)

How often do you use it (daily, weekly, monthly) _____

How much cannabis do you consume per treatment? _____

What method do you currently use to consume the cannabis - **Circle methods used:**

Ingest Vaporize Smoke

Which best describes how these symptoms collectively interfere with your life?

(Rate on a scale from 1-10, 1 being not at all and 10 being completely)

Work: **1 2 3 4 5 6 7 8 9 10**

Sleep: **1 2 3 4 5 6 7 8 9 10**

Mood: **1 2 3 4 5 6 7 8 9 10**

Relationships: **1 2 3 4 5 6 7 8 9 10**

Physical Activity: **1 2 3 4 5 6 7 8 9 10**

Social History:

How often do you drink alcohol and how many drinks do you typically consume when you drink?
(For example: Typically drink 6-10 drinks every weekend) _____

How often do you use any recreational drugs other than marijuana and what do you use? (Heroin, Cocaine, Ecstasy, Acid, Mushrooms, etc.) _____

How often do you smoke cigarettes and how many do you smoke each day? _____

Past Surgical History:

Please list any surgeries that you have had in the past. Include the reason, date, hospital and doctor who performed the surgery:

Past Medical History:

Name and contact of the Physician who treats you for the condition you are being evaluated for:

Name Address City State Zip

Phone/Fax

Approximate date (month/year) of the last time you visited your doctor: _____

Please list any medical condition that 1) a physician has evaluated you for 2) you were admitted to a hospital for or 3) you are currently being treated for : (For example: Arthritis, High Blood Pressure, Glaucoma, Migraine Headaches, Diabetes, Anxiety, Asthma, Hepatitis C)

Please list the medications that you are currently taking on a daily or occasional basis (please include over the counter medications such as Claritin): Include the dosage and frequency of use:

FEMALES: Currently using birth control? (Specify) _____

Are you allergic to any medications? YES ___ NO ___ If yes, please list your drug allergies below:

Employment History:

Are you employed: YES ___ NO ___

What is your occupation?

If you are NOT employed, what is your status?

- ___ Unemployed
- ___ Retired
- ___ Disabled
- ___ Workers Compensation
- ___ Student
- ___ Other

Family History:

Marital Status:

- Single
- Married
- Divorced
- Widowed
- Domestic Partnership

Do you have children? YES ___ NO ___

Are you currently pregnant? YES ___ NO ___

In your family has there been a history of: (with Father, Mother, Brother, Sister, etc.)

- Heart Disease _____
- Arthritis _____
- High Blood Pressure _____
- Depression _____
- Cancer _____
- Alcohol Abuse _____
- Drug Abuse _____
- Diabetes _____

Patient Signature:

___ “I hereby certify that the above information regarding my medical history and condition is true and correct to the best of my knowledge. I understand that Advanced Medical Associates are only seeing me to evaluate my suitability under Michigan law for the use of medical marijuana as an additional treatment for my qualifying health problems. Advanced Medical Associates is not assuming responsibility for treatment of any healthcare problems or disorders. Nor are they responsible for any adverse reaction or conditions that may occur due to the use of medical marijuana. I understand that if I need care or treatment for any healthcare problem or disorder, it is my responsibility to seek care from another provider.”

Patient Signature

Date

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
FOR MICHIGAN MEDICAL MARIJUANA CERTIFICATION**

Patients Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

I request and authorize _____
(Doctor/Provider/Clinic Name & Address)
To release healthcare information of the patient named above to:

**Advanced Medical Associates
P.O. Box 330
Lambertville, Mi. 48144
(734)347-2127
Fax (734) 847-4711
www.amamichigan/ohio.com**

This request and authorization applies to healthcare information relating to the following treatment or condition. Check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Colitis | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Agitation of Alzheimer's Disease | <input type="checkbox"/> HIV/AIDS | |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis | <input type="checkbox"/> Nail Patella | |
| <input type="checkbox"/> Cachexia or Wasting Syndrome | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Severe & Chronic Pain | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Severe & Persistent Muscle Spasms | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Severe Nausea | |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Spinal Cord Injury | |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Ulcerative Colitis | |

I understand that;

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization.
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.

Patient Signature: _____ Date: _____
Print Name: _____

**THIS AUTHORIZATION EXPIRES SIX MONTHS
AFTER IT IS SIGNED.
A FAX/copy of this authorization shall be considered as
valid as the original.**