Medical Questionnaire

Today's Date: ______________________

Name: ____
First M.I. Last Name

Date of Birth: ______________ Home #: (   ) ______________ Cell #: (   ) ______________

Address ____
Street City Zip County

E-Mail ______________________________ SSN ______________________

Emergency Contact ____________________ ____________________ Phone: (   ) ______________
Name Relationship

Legal Representative ____
Name Phone number

Please tell us where you heard about Green Way Holistic – check all that apply.

__ Physician __ Compassion Club __ Family member/Friend __ Internet / website

__ Newspaper __ Print materials __ TV ad __ Radio ad __ Other ______________

Do you want record of today's visit sent to your Primary Care Provider? Yes No

Primary Care Provider Information

Name: ____________________ Phone: ____________________ Specialty: ____________________

Address: ____________________ ____________________ __________ __________
City State Zip

____ Please initial to acknowledge that you have brought us all the medical records you can obtain from doctors you have seen for your qualifying condition.

Please list all medications (prescription and/or over the counter) that you are currently taking and their dosage (if known):

Medication Name	Strength/Dose	# of times per day	Start date (month/year)	Target Symptom
Psych:				
Other RX:				
OTC:				

Do you have any known drug allergies? No ___ Yes ___

If yes, please list: ____

Patient Name: ________________________________ **Date of Birth:** ________________________

Social History

- [ ] Smoker
- [ ] Other tobacco products
- [ ] Street Drugs (Other than Marijuana, strictly confidential)
- [ ] Alcohol __________ Daily __________ Weekly

List any hospitalizations, the reason and duration

-
-
-
-
-
-
-

General: Mark if you have had any of the following in the past 3 months

- [ ] Fever
- [ ] Chills
- [ ] Night Sweats
- [ ] Weight Gain
- [ ] Weight Loss
- [ ] Marked Fatigue
- [ ] Chest Pain
- [ ] Difficulty Breathing
- [ ] Nausea or vomiting
- [ ] Dizziness

Please mark diseases, symptoms or other items corresponding to your current and past health Problems:

Eyes, Ears, Nose, Throat

- [ ] Glaucoma
- [ ] Cataracts
- [ ] Hearing Loss [ ] Left [ ] Right [ ] Both
- [ ] Frequent Ear Infections
- [ ] Seasonal Allergies
- [ ] Sinus Problems
- [ ] Difficulty Swallowing
- [ ] Eye Pain
- [ ] Other____________________________

Cardiovascular

- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Heart Attack
- [ ] Angina
- [ ] Cardiac Arrhythmias
- [ ] Palpitations
- [ ] Pace Maker
- [ ] Stroke (Lasting deficits)
- [ ] TIA (Symptoms resolved completely)
- [ ] Peripheral Vascular Disease
- [ ] Other____________________________

Respiratory

- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Chronic Bronchitis
- [ ] Pulmonary Embolism
- [ ] DVT (Blood Clot)
- [ ] Other Lung Problems________________________

Integumentary

- [ ] Psoriasis
- [ ] Photosensitivity
- [ ] Skin Cancer
- [ ] Other Skin Problems_________________________

Gastrointestinal

- [ ] Chronic Constipation
- [ ] Chronic Diarrhea
- [ ] GERD
- [ ] Ulcers
- [ ] Heartburn
- [ ] Crohn's
- [ ] Colitis
- [ ] Cachexia or Wasting Syndrome
- [ ] Persistent Nausea
- [ ] Frequent Vomiting
- [ ] Blood in Stool
- [ ] Decreased Appetite
- [ ] Diverticulitis
- [ ] Other_________________________

Nervous System

- [ ] Migraine or other Headaches
- [ ] Nerve pain or Neuropathy
- [ ] Insomnia / Sleeping Disorder
- [ ] Parkinson's Disease
- [ ] Post Herpetic Neuralgia (Shingles pain)
- [ ] Head Injury
- [ ] Multiple Sclerosis
- [ ] Epilepsy/Seizures
- [ ] Severe and Chronic Pain
- [ ] Other___________________________

Renal

- [ ] Kidney Disease
- [ ] Require Dialysis
- [ ] Frequent Kidney Stones
- [ ] Other______________________________

Infectious Disease

- [ ] HIV/AIDS
- [ ] Hepatitis A B C
- [ ] Tuberculosis
- [ ] Valley Fever
- [ ] Other __________________________________

Cancers

- [ ] Cancer : Type______________________________
- [ ] Cancer: Type______________________________
- [ ] Family History of Cancer diagnosed before age 50 yrs

****Are you currently or previously Treated with:*

- [ ] Chemotherapy
  Started:_________________________
  Duration:_______________________
  Treatments Per Week:____________
  End:___________________________

- [ ] Radiation Therapy
  Body Part:_____________________
  Start:__________________________
  Duration:_______________________
  End:___________________________

Metabolic/Endocrine

- [ ] Diabetes Type I or II (circle one)
- [ ] Thyroid Disorder
- [ ] Anemia
- [ ] Obesity
- [ ] Polycystic Ovarian Syndrome (PCOS)
- [ ] Metabolic Syndrome
- [ ] Other:___________________________

Musculoskeletal

- [ ] Severe and Persistent Muscle Spasms
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Broken Bone: Where:__________________________
- [ ] Degenerative Disk Disease
- [ ] Rheumatoid Arthritis
- [ ] Other Arthritis
- [ ] Fibromyalgia
- [ ] Joint Pain
- [ ] Muscle Pain
- [ ] Bone Pain
- [ ] Amyotrophic Lateral Sclerosis
- [ ] Other ___________________________________

Surgeries

- [ ] Tonsillectomy
- [ ] Appendectomy
- [ ] Back Surgery
- [ ] Other bone/joint surgery
- [ ] Procedure to decrease pain:__________________________
- [ ] Injections to treat painful areas
- [ ] Transplant Surgery
- [ ] Abdominal Surgeries
- [ ] Heart Surgery
- [ ] Other Surgery or Procedure_________________________

Mental Health

- [ ] Panic Disorder
- [ ] Depression
- [ ] Anxiety
- [ ] Bipolar Disorder
- [ ] Schizophrenia
- [ ] Alzheimer's Disease
- [ ] Dementia
- [ ] Obsessive-compulsive disorder (OCD)
- [ ] Post-traumatic stress disorder (PTSD)
- [ ] ADD/ADHD
- [ ] Suicidal thoughts, plans, or attempts
- [ ] History of abuse
- [ ] History of drug abuse
- [ ] Other______________________________

THIS SECTION FOR MEN ONLY

- [ ] Decreased Libido
- [ ] Prostate Enlargement
- [ ] Problems Urinating
- [ ] Erectile Dysfunction
- [ ] Other __________________________________

THIS SECTION FOR WOMEN ONLY

- [ ] Heavy Periods
- [ ] PMS or PMDD
- [ ] Pelvic inflammatory disease
- [ ] Decreased Libido
- [ ] Hot Flashes
- [ ] Other_____________________

Could you be pregnant: YES NO

If no, check reason(s) why:

- [ ] Hysterectomy Full Partial Date:________________
- [ ] Tubal Ligation Date:________________________
- [ ] Natural Post menopause Date of last period:____________
- [ ] Correctly and consistently using a birth control method
  If yes, please list method(s)

If you think you might be pregnant, or have the possibility of being pregnant, please fill out the following section:

Date of last period: ___________________________

Have you ever been pregnant? YES NO
If yes, please list most recent date of delivery and/or spontaneous/induced abortion:

Are you currently breastfeeding? YES NO

Are you trying to become pregnant? Yes NO

We may ask you to take a pregnancy test.

I certify that the above information is true and accurate to the best of my ability.

____ _____________________________

Signature (Required) Date:

YOUR FOLLOW-UP CARE

Please call us within 30 days to inform us how the program is working for you. We will need you to schedule a follow-up visit in 6 months for an in-office review of dosing methods and effects with our physicians. We will renew your state registry dosage prescription up to 3 times, good for up to 70 days within the next 6 month period. Call Green Way Holistic anytime to discuss a change in your dosage method or efficacy. After 3 state registry dosage prescription renewals you will need to come back to Green Way for an office visit whether or not it has been a 6 month period.

As always, our business staff is available 5 days a week to answer any questions you may have.

You can email us at ask@GreenWayHolistic.com or call us at 855-492-9465.
We expect to provide follow-up care to you to monitor the efficacy of your medical use of marijuana.

____ ____________________
Patient Name (please print) Date of birth

____ ____________________
Patient signature Today's Date

THE PHYSICIAN MUST INITIAL EACH LINE BELOW:

I do hereby declare that the written certificate was prepared in the course of a bona fide physician-patient relationship in which each of the following were present as part of the treatment or counseling relationship:

________ **I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient.**

________ **I have created and will maintain records of this patient's condition in accord with medically accepted standards.**

________ **I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marijuana as a treatment of this patient's debilitating medical condition.**

<u>"No marijuana-related legal action pending" Agreement</u>

By signing below, I, ____, assert that

as of today, the _____ day of _________________________ in the year ______________,

I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I also further assert that any and all information I give pertaining to my "qualifying condition" as defined by the State of Florida, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Green Way Holistic harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Green Way Holistic – a Florida Corporation.

Signature of Patient ____ Date ______________

Signature of Witness ____ Date ______________
Green Way Holistic

2017