Medical Cannabis Card Pre-Consultation Form

Please write LEGIBLY and CLEARLY. All questions must be answered prior to the consultation. If you are printing this before your consultation, make sure you print it one-sided.

E-mail (**required** for card application): _____ (can only have one e-mail per account in the database)

Full name: _____ Address: _____

Date of birth: _____ Age: _____ Sex: _____ City/State/Zip: _____

Primary phone number: _____

Most recent primary physician or health care provider

Name of practitioner: _____

Address: _____

City/State/Zip: _____

Reason for Cannabis Treatment (must have one or more to qualify) – if you do not have one of the below, you will NOT be approved.

- ☐ Cachexia or muscle wasting
- ☐ Seizures
- ☐ Severe nausea
- ☐ Chronic, severe, debilitating pain
- ☐ Chronic muscle spasms

Explain the above-checked symptom(s) you experience (including frequency, severity, and duration) and the cause (if known; *for example: muscle spasms = due to multiple sclerosis or severe nausea = due to migraine headaches or chronic pain = due to rheumatoid arthritis, low back pain, etc.*) – do NOT discuss unrelated symptoms which are not qualifying (*e.g. insomnia, anxiety, depression, PTSD, etc.*)

_____

_____

_____

Do you already use cannabis to treat the above symptom(s)?

- ☐ Yes
- ☐ No

If yes, does it help with your symptom(s)?

- ☐ Yes
- ☐ No

List treatments you have tried for the symptoms above, how long each treatment was attempted, and outcome of the treatment

Treatment Duration Outcome

_____

_____

_____

_____

List all of your medical illnesses

_____

_____

_____

_____

_____

_____

List all current medications you are taking (including over-the-counter medications) and dosage

Name of medication Dose (e.g. milligrams) Frequency (e.g. twice daily)

_____

_____

_____

_____

_____

_____

_____

List any drug allergies you have

_____

_____

_____

Answer yes or no to the below questions

Have you ever used legal/commercially-available forms of CBD (cannabidiol)?	YES	NO
Have you ever been diagnosed with a mental illness characterized by panic/anxiety attacks or hallucinations?	YES	NO
Have you ever had a heart attack (myocardial infarction) or been told you have coronary artery disease?	YES	NO
Do you have asthma, chronic bronchitis, chronic obstructive pulmonary disease, or emphysema?	YES	NO
Women only:		
Are you currently pregnant or have reason to believe you might be pregnant?	YES	NO
Are you currently breast-feeding?	YES	NO