**Patient Name:** Click here to enter text. **DOB:** Click here to enter a date.

**Qualifying Diagnosis:**

Cancer Epilepsy Glaucoma Intractable migraines unresponsive to other treatment

A chronic medical conditions that cause severe, persistent pain or persistent muscle spasms, including but not limited to those associated with multiple sclerosis, seizures, Parkinson’s disease, and Tourette’s syndrome. Please specify underlying medical condition: Click here to enter text.

Debilitating psychiatric disorders, including, but not limited to, post-traumatic stress disorder, if diagnosed by a state licensed psychiatrist. Diagnosing psychiatrist: Click here to enter text.

Human Immunodeficiency virus or acquired immune deficiency syndrome.

A chronic medical condition that is normally treated with a prescription medication that could lead to a physical or psychological dependence, when a physician determines that medical use of marijuana could be effective in treating that condition and would serve as a safer alternative to the prescription medication. Specify chronic medical condition: Click here to enter text.

A terminal illness. Specify terminal illness: Click here to enter text.

Any other chronic, debilitating or other medical condition, including, but not limited to, hepatitis C, amyotrophic lateral sclerosis, inflammatory bowel disease, Crohn’s disease, Huntington’s disease, autism, neuropathies, sickle cell anemia, agitation of Alzheimer’s disease, cachexia, and wasting syndrome. Please specify debilitating disease or medical condition: Click here to enter text.

**History of this Illness**:

When did it start?Click here to enter text.

Any previous testing?

What: Click here to enter text.

When: Click here to enter text.

Current severity?  Mild Moderate Severe (Check One)

Anything that makes it better? Click here to enter text.

Anything that makes is worse? Click here to enter text.

**Past Medical History**: (Check all that apply)

Hypertension Diabetes  Asthma  Coronary Artery Disease  Arrhythmia  COPD

Cancer (type): Click here to enter text.  Other: Click here to enter text.

Autoimmune Diseases:

Rheumatoid Arthritis  Lupus  Hashimoto’s  Graves’ disease

Crohn’s  Ulcerative Colitis  Psoriasis  Other: Click here to enter text.

**Past Surgical History:**

List any surgeries: Click here to enter text.

**Social History:**

Tobacco Use:  No  Yes How much? Click here to enter text.

Alcohol Use:  No  Yes How much? Click here to enter text.

**Medication List with Dosages:**

Click here to enter text.

**Allergies:**

Click here to enter text.