Todays Date________________

New Patient Registration and Health History

3/03/2010

Patient Basic Information – Print Clearly

Full Legal Name____

Address____

SSN Number____

Colorado State Medical Marijuana License Number____________________________________

Date of Issue for your CO Medical Marijuana License__________________________________

Expiration Date for your CO Medical Marijuana License________________________________

Primary Phone Number____

Secondary Phone Number____

Email Address____

Emergency Contact Name____

Emergency Contact Phone____

Emergency Contact Relationship____

CO Drivers License Number____

Gender (male/female)________________________ Date of Birth________________________

Primary MMJ Caregiver____

Secondary MMJ Caregiver ____

Ethnicity____

How did you here about A20labs____

Occupation____

Current Employer____

Current Employer Address____

Current Employer Phone____

Principle Illness/Complaint for Seeking Treatment___________________________________

Health Objectives____

How Frequently do you Use Medical Marijuana (MMJ)________________________________

What Strains of MMJ have you used____

What MMJ strains are most effective for you_______________________________________

What technique do you use for inhalation of MMJ___________________________________

Do you use edible forms of MMJ____

How frequently do you used edibles____

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Allergies Please describe reactions

☒**Shellfish** ☒**IV Contrast** ☒**Penicillins** ☒**Other,** specify

Please list medications you are taking. Include ALL over the counter medications, herbs & vitamins.

Medication & Dose	Frequency	**Medication & Dose**	Frequency

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Past Medical History Check "yes" or "no" for each problem listed.			
Adrenal Dysfunction	☒Yes ☒No	**Irregular Heart Rhythm**	☒Yes ☒No
Alzheimer	☒Yes ☒No	**Kyphosis**	☒Yes ☒No
Amyotrophic Lateral Sclerosis	☒Yes ☒No	**Liver Dysfunction**	☒Yes ☒No
Anorexia or Bulimia	☒Yes ☒No	**Kidney Failure, or Dysfunction**	☒Yes ☒No
Anxiety Disorder	☒Yes ☒No	**Malignancy** If yes, describe below	☒Yes ☒No
Arteriovenous Malformations (AVMs)	☒Yes ☒No		
Arthritis	☒Yes ☒No		
Asthma	☒Yes ☒No	**Mania**	☒Yes ☒No
Autoimmune Disease	☒Yes ☒No	**Muscular Dystrophy**	☒Yes ☒No
Bipolar Disorder	☒Yes ☒No	**Myocardial Infarction (Heart Attack)**	☒Yes ☒No
Bleeding Disorder	☒Yes ☒No	**Narcolepsy**	☒Yes ☒No
Cataracts	☒Yes ☒No	**Obstructive Sleep Apnea**	☒Yes ☒No
Cerebrovascular Accident (Stroke)	☒Yes ☒No	**Organ Transplant** If yes, describe	☒Yes ☒No
Chemotherapy If yes, state when	☒Yes ☒No		
		Osteoporosis	☒Yes ☒No
Claudication	☒Yes ☒No	**Pancreatitis**	☒Yes ☒No
Clotting Disorder	☒Yes ☒No	**Periodic Limb Movement Disorder**	☒Yes ☒No
Congenital Heart Defects	☒Yes ☒No	**Peripheral Artery Disease**	☒Yes ☒No
Coronary Artery Disease	☒Yes ☒No	**Personality Disorder**	☒Yes ☒No
COPD	☒Yes ☒No	**Pituitary Dysfunction**	☒Yes ☒No
Cystic Fibrosis	☒Yes ☒No	**Polycystic Ovarian Syndrome**	☒Yes ☒No
Depression	☒Yes ☒No	**Pulmonary Artery Hypertension**	☒Yes ☒No
Diabetes	☒Yes ☒No	**Pulmonary fibrosis**	☒Yes ☒No
Dialysis	☒Yes ☒No	**Radiation Therapy** If yes, explain	☒Yes ☒No
Eclampsia or Pre-eclampsia	☒Yes ☒No		
Endocarditis	☒Yes ☒No	**Recurrent Infections**	☒Yes ☒No
Endometriosis	☒Yes ☒No	**Restless Leg Syndrome**	☒Yes ☒No
End Stage Renal Disease	☒Yes ☒No	**Sarcoidosis**	☒Yes ☒No
Erectile Dysfunction	☒Yes ☒No	**Schizophrenia**	☒Yes ☒No
Esophageal Dysfunction	☒Yes ☒No	**Scleroderma**	☒Yes ☒No
Fibromyalgia	☒Yes ☒No	**Scoliosis**	☒Yes ☒No
Gallstones	☒Yes ☒No	**Seizure Disorder**	☒Yes ☒No
Gastritis or Gastric Ulcers	☒Yes ☒No	**Sickle Cell**	☒Yes ☒No
GERD (reflux problems)	☒Yes ☒No	**Sjogren**	☒Yes ☒No
Glaucoma	☒Yes ☒No	**Skin Disorders (Psoriasis, Acne)**	☒Yes ☒No
Heart or Valve Defects	☒Yes ☒No	**Thalassemia**	☒Yes ☒No
Hemochromatosis	☒Yes ☒No	**Thrombocytopenia**	☒Yes ☒No
Hemorrhoids	☒Yes ☒No	**Thrombophilia**	☒Yes ☒No
Hepatitis	☒Yes ☒No	**Transfusions**	☒Yes ☒No
HIV or AIDS	☒Yes ☒No	**Tuberculosis**	☒Yes ☒No
Hypertension	☒Yes ☒No	If yes, have you been treated?	☒Yes ☒No
Hyperthyroidism	☒Yes ☒No	**Urinary retention or urgency**	☒Yes ☒No
Hypotension	☒Yes ☒No	**Vasculitis**	☒Yes ☒No
Hypothyroidism	☒Yes ☒No	**Visual defects**	☒Yes ☒No
Inflammatory Bowel Disease	☒Yes ☒No	**Vocal cord dysfunction/paralysis**	☒Yes ☒No

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Health Care Consumer Questionnaire Patient DOB Date

Review of Systems			
In the last 6 months have you experienced the following symptoms. Check either "yes" or "no" for each symptom.			
Constitutional		**Genitourinary**	
Weight Loss or Gain	❑Yes ❑No	Blood in your urine	❑Yes ❑No
Appetite changes (increased or decreased)	❑Yes ❑No	Menstrual changes	❑Yes ❑No
Fatigue, profound and impairs daily function	❑Yes ❑No	Urinating that is painful or difficult	❑Yes ❑No
Fever	❑Yes ❑No	Erection problems	❑Yes ❑No
Shakes/sweats from lack of alcohol or drug	❑Yes ❑No	Vaginal discharge or bleeding	❑Yes ❑No
Eyes		**Musculoskeletal**	
Eye pain or drainage	❑Yes ❑No	Broken bones	❑Yes ❑No
Visual changes	❑Yes ❑No	Joint pain or swelling	❑Yes ❑No
Dry, irritated eyes	❑Yes ❑No	Muscle aches	❑Yes ❑No
ENT/Mouth		Muscle weakness	❑Yes ❑No
Ear pain or drainage	❑Yes ❑No	Back pain	❑Yes ❑No
Frequent sinus infections	❑Yes ❑No	**Skin/Breasts**	
Hearing changes or loss	❑Yes ❑No	Masses or lumps	❑Yes ❑No
Nosebleeds	❑Yes ❑No	Nipple discharge	❑Yes ❑No
Dizziness	❑Yes ❑No	Rashes or nonhealing ulcers	❑Yes ❑No
Respiratory		**Neurologic**	
Blood in your sputum	❑Yes ❑No	Seizures	❑Yes ❑No
Chest tightness	❑Yes ❑No	Coughing or choking with swallowing	❑Yes ❑No
Cough lasting >1 month, productive or not	❑Yes ❑No	Excessive daytime sleepiness	❑Yes ❑No
Shortness of breath	❑Yes ❑No	Extremity pain or burning sensations	❑Yes ❑No
Wheezing	❑Yes ❑No	Hallucinations	❑Yes ❑No
Chest pain with inhalation or coughing	❑Yes ❑No	Numbness or tingling	❑Yes ❑No
Cardiovascular		Difficulty falling asleep, staying asleep	❑Yes ❑No
Chest pain or heaviness	❑Yes ❑No	**Endocrinologic**	
Palpitations	❑Yes ❑No	Hair loss	❑Yes ❑No
Fainting or near fainting spells	❑Yes ❑No	Frequent urination	❑Yes ❑No
Swelling of feet or legs	❑Yes ❑No	Increased thirst	❑Yes ❑No
Shortness of breath lying flat in bed	❑Yes ❑No	Heat or cold intolerance	❑Yes ❑No
Gastrointestinal		**Heme/Lymph**	
Abdominal pain	❑Yes ❑No	Bleeding from gums or nose	❑Yes ❑No
Blood in your stool	❑Yes ❑No	Unexplained bruising	❑Yes ❑No
Constipation	❑Yes ❑No	Night Sweats	❑Yes ❑No
Diarrhea or Food Intolerance	❑Yes ❑No	Swollen, painful lymph nodes	❑Yes ❑No
Heartburn or Indigestion	❑Yes ❑No	**Allergy/Immun**	
Vomiting or nausea lasting for >1 day	❑Yes ❑No	Watery eyes	❑Yes ❑No
Swallowing difficulty	❑Yes ❑No	Runny nose	❑Yes ❑No
Psych		Food intolerance	❑Yes ❑No
Anxiety without clear explanation	❑Yes ❑No	Frequent skin sores	❑Yes ❑No
Sadness lasting for days or weeks	❑Yes ❑No		
Hearing voices	❑Yes ❑No		
Thoughts of hurting yourself	❑Yes ❑No		
Thought of hurting others	❑Yes ❑No		
Fear of people, places or things	❑Yes ❑No		

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