MedPharm Iowa Dispensary – Patient Intake Form

Patients, please fill out the following form. If you are a registered caregiver for a patient who has been certified for medical cannabis, please fill out the form using the patient's information.
Please note who is filling out this form by checking the appropriate box:

☐ Patient ☐ Physician ☐ Caregiver

Patient ID: _____

DOB: _____ Date: _____

Patient Contact Information

Name: _____

Address: _____

City/State/ZIP: _____

Phone (Main): _____

Phone (Alternative): _____

Email: _____

Certifying Provider Information

Provider Name: _____

Address: _____

Phone: _____

Registered Caregiver Contact Information (if applicable)

Name: _____

Address: _____

City/State/ZIP: _____

Phone (Main): _____

Phone (Alternative): _____

Email: _____

Emergency Contact Information

Contact Name: _____

Phone: _____

Relationship to Patient: _____

MEDICAL HISTORY

1. For which condition(s) has the patient received a certification for medical cannabis? Please check all that apply.

_____ Amyotrophic lateral sclerosis (ALS)
_____ Parkinson's disease (PD)
_____ Cancer
_____ Seizures
_____ Crohn's disease
_____ Terminal illness (please specify diagnosis): _____
_____ HIV/AIDS
_____ Ulcerative colitis
_____ Multiple sclerosis (MS)
_____ Untreatable pain (please specify diagnosis or type of pain): _____
_____ Pediatric autism

2. Has the patient ever been treated for any of the following? Please check one option per row.

Condition	**Yes**	**No**	**Notes**
Anxiety			
Arthritis			
Asthma			
Bipolar disorder			
Chronic Obstructive Pulmonary Disease (COPD)			
Depression			
Diabetes			
Glaucoma			
Heart disease (including myocardial infarction, arrythmia)			
Hepatitis or other liver disease			
Hypertension (high blood pressure)			
Hypotension (low blood pressure)			
Insomnia			
Kidney disease or kidney failure			
Schizophrenia or psychosis			
Seizures (epilepsy)			
Substance abuse			
Joint pain			
Fatigue			
Migraines			
Intraocular pressure			

3. For which of the symptoms below is the patient seeking relief? Check all that apply. Next to each box that is checked, please indicate the severity of the patient's symptoms using a scale of 1 through 10, (1 = not interfering with life at all and 10 = substantially interfering with life).

Select (x)	Symptom	Severity (1-10)
	Chronic pain	
	- Gastrointestinal pain	
	- Neuropathy	
	- Arthritis	
	Lack of appetite	
	Nausea and/or vomiting	
	Muscle spasms	
	Muscle spasticity	
	Tremors	
	Insomnia	
	Seizures	
	Anxiety	
	Self injurious behavior	
	Other:	

ADDITIONAL QUESTIONS

	Yes	No	N/A or Unkown
Does the patient have a heart condition or heart disease?			
- If yes to above, is the patient's condition currently being managed by a healthcare provider?			
Is the patient prone to dizzy spells or fainting?			
Is the patient prone to falls or considered to be a fall risk?			
Is the patient currently pregnant, think they may be pregnant, or planning to become pregnant?			
Is the patient currently breastfeeding?			

Please list ALL medications, supplements, nutraceuticals, vitamins, and herbal products the patient is currently taking.

Product	Dose	Frequency	Condition being treated

	Yes	No	N/A or Unknown
Is the patient currently taking Clobazam (Frisium, Urbanol, Onfi, Tapclob)?			
Is the patient currently taking Valproate (Convulex, Depakote, Epilim, Stavzor)?			
Is the patient currently taking Warfarin (Coumadin, Jantoven)			
Has the patient ever experienced a severe adverse event related to a medication OR does the patient consider themselves to be medication sensitive?			
If yes to above, please list the medication(s):			
Please list any known allergies the patient has to medication(s) or food:			

MEDICAL CANNABIS HISTORY

Patient's level of experience with cannabis:

_____ No Experience _____ Some Experience _____ Experienced User

If the patient has self-medicated with cannabis before, please list the method(s) of consumption, dose (if known), CBD:THC ratio (if known), and frequency.

Additional Notes
Is there additional information that the patient would like us to know? If yes, please include that information here.

MedPharm Patient Consultant Notes
[To be filled out by the MedPharm Patient Consultant]