



# MedPharm Iowa Dispensary - Patient Intake Form

Please note who is filling out this form by checking the appropriate box:

Patient

Physician

Caregiver

Patient ID: \_\_\_\_\_

Active Duty/Veteran?: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

## Patient Contact Information

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State/ZIP:

\_\_\_\_\_

Phone (Main):

\_\_\_\_\_

Phone (Alternative):

\_\_\_\_\_

Email:

\_\_\_\_\_

## Certifying Provider Information

Provider Name:

\_\_\_\_\_

## Registered Caregiver Contact Information (if applicable)

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State/ZIP:

\_\_\_\_\_

Phone (Main):

\_\_\_\_\_

## 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, arrhythmia)			
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?			



Please list any known allergies the patient has to medication(s) or food:

What is your current quality of life BEFORE cannabis treatment?

\_\_\_ Very Bad    \_\_\_ Bad    \_\_\_ Neither Good nor Bad    \_\_\_ Good    \_\_\_ Very Good

## 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]

*Complete the patient intake form and email it to [dispensary@medpharmiowa.com](mailto:dispensary@medpharmiowa.com). Once received, the dispensary staff will then follow up with you for via phone to schedule the consultation.*