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 Registration #: _____ Active Duty/ Veteran?: ☐ Yes ☐ No

DOB: _____ Today's 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):

Email:

Emergency Contact Information

Name:

Phone:

Relationship to Patient:

How Did you hear about us?

☐ Friends/Family ☐ Website
☐ News Outlet ☐ Medical Professional
☐ Social Media ☐ Event

Were you referred by an existing patient?

If so, please list their name here:

_____

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
- ☐ HIV/AIDS
- ☐ Ulcerative colitis
- ☐ Multiple sclerosis (MS)
- ☐ Autism
- ☐ Post Traumatic Stress Disorder
- ☐ Corticobasal Degeneration
- ☐ Chronic pain *(please specify)*: _____
- ☐ Terminal illness *(please specify)*: _____

2. Has the patient ever been treated for any of the following?

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)*	☐	☐	
Hypo-tension *(low blood pressure)*	☐	☐	
Insomnia	☐	☐	
Kidney disease or kidney failure	☐	☐	
Schizophrenia or psychosis	☐	☐	
Seizures *(epilepsy)*	☐	☐	
Substance abuse	☐	☐	
Joint pain	☐	☐	
Fatigue	☐	☐	
Migraines	☐	☐	
Intraocular pressure	☐	☐	

3. Rate the severity of your symptoms. 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). *Check all that apply.*

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 UNKNOWN
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)*	☐	☐	
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:

PRODUCT/ALLERGY

What is your current quality of health **BEFORE** cannabis treatment?

☐ Very Bad ☐ Bad ☐ Neither Good nor Bad ☐ Good ☐ Very Good

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.

PRODUCT	DOSE	FREQUENCY

MedPharm Iowa Patient Consultant Notes *(To be filled out by the MPI staff)*