OFFICE USE ONLY

POS _____	Survey _____
Notes _____	SB _____

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.

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
☐ News Outlet
☐ Social Media
☐ Website
☐ Medical Professional
☐ 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
- ☐ Intellectual Disability
- ☐ Post Traumatic Stress Disorder
- ☐ Corticobasal Degeneration
- ☐ Chronic pain
- ☐ Terminal illness

2. 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?			
Is the patient currently pregnant, think they may be pregnant, or planning to become pregnant?			

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

If the patient has used cannabis in the past, 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)*

MED PHARM
IOWA

REWARDS PROGRAM

Collect points as you make purchases. Points are redeemable towards MedPharm apparel, stickers and cannabis cash. If interested, please fill out, read and sign below:

FULL NAME: _____

BIRTHDAY: _____

MOBILE NUMBER: _____

EMAIL ADDRESS: _____

BY SIGNING BELOW, YOU AGREE TO THE FOLLOWING:

Allow MedPharm Iowa to capture and retain your contact & purchase information in order to provide you with more personalized marketing and communications experience.

By providing your mobile phone number and email, you consent to receive marketing focused text messages and calls, including via automatic telephone dialing system or prerecorded or artificial voice from MedPharm Iowa. Consent is not required as a condition of purchasing any goods or services. *Standard per minute call and message rates may apply. Opt out at any time by replying "STOP" to text messages.*

SIGNATURE: _____