OFFICE USE ONLY

POS _____ Survey _____
Notes _____

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:

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 medicationsensitive?			
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	FREQUENCY

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

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