ADVANCED INTEGRATIVE MEDICINE

Terese A. Taylor, M.D.

Family Medicine and Medical Aesthetics

PATIENT INTAKE FORM

Date: _____ Gender: ☐ M / ☐ F

PATIENT NAME :_____ Age: _____ Date of Birth:_____/_____/_____

PREFERRED CONTACT METHOD: ☐ Mobile phone ☐ Home phone ☐ Work Phone ☐ Email

Email address: _____(*please write **LEGIBLY!***)

Home Address: _____ City: _____State _____Zip _____

Alt Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone:_____

Social Security # _____ DMV ID # _____

Employer: _____ Occupation: _____

Work Phone: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

LEGAL REPRESENTATIVE(S):

Name: _____ Phone: _____

Home Address: _____ City: _____State:_____Zip:_____

Name: _____ Phone: _____

Home Address: _____ City: _____State:_____Zip:_____

PATIENT HISTORY:

Please list the main reason for your visit today and any other specific concerns or problems you want the doctor to discuss with you.

_____

_____

Are you presently under the care of another medical physician and/or clinic? ☐ YES / ☐ NO

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What is your medical qualifying condition?

- ☐ Cancer
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Positive status for HIV
- ☐ AIDS
- ☐ Post Traumatic Stress Disorder
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Crohn's disease
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Medical conditions of the same kind or class as or comparable to those enumerated in paragraphs (a)-(j)
- ☐ A terminal condition diagnosed by a physician other than the qualified physician issuing the physician certification?
- ☐ Chronic nonmalignant pain

Do you have physician documentation supporting the medically qualifying condition? ☐ YES / ☐ NO

Florida's Amendment 2 it indicates that "other debilitating conditions of like, kind or class **may be eligible** for a medical marijuana certification". These **may** include the following.

- Anorexia
- Arthritis
- Cachexia
- Chemotherapy Side Effects
- Chronic Back Pain
- Chronic Headaches
- Chronic Neck Pain
- Cyclical Vomiting Syndrome
- Essential Tremor
- Fibromyalgia
- Hepatitis C
- Irritable Bowel Syndrome
- Lyme Disease
- Migraine
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Neuropathy
- Post-Polio Syndrome
- Progressive Supranuclear Palsy
- Radiation Therapy Side Effects
- Seizures
- Severe & Chronic Pain
- Sickle Cell Anemia
- Spasticity
- Spinal Muscular Atrophy
- Tardive Dyskinesia
- Ulcerative Colitis
- Vertebral Compression Fractures

Do you have any other medical conditions for which you believe you would qualify for medical marijuana? ☐yes / ☐ no
Please explain:

_____

_____

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Are you currently pregnant? ☐ YES / ☐ NO Are you breastfeeding? ☐ YES / ☐ NO

Are you using birth control? ☐ YES/ ☐ NO

I hereby certify that the above information regarding my medical history and condition is true and correct to the best of my knowledge.

Signature: _____

COMPLETE MEDICAL HISTORY FORM DATE: _____

NAME: _____ **AGE**: _____ **DATE OF BIRTH:** _____

1. **PAST MEDICAL HISTORY**

   A. **Surgeries:**
   Date: Where: Reasons:
   _____
   _____
   _____

   B. **Hospitalization: (other than for surgeries)**
   Date: Where: Reasons:
   _____
   _____
   _____

   C. **Present Medications (prescription and over the counter):**
   _____
   _____
   _____

   Herbs and Supplements:
   _____

   D. **Allergies: Are you allergic to any:**
   Medications: What Reaction?:
   _____
   _____

   Allergies to Other Substances, Food, Etc:

   _____
   _____

2. FAMILY HISTORY

Father: Age (if living): _____ Age (at death): _____ Cause of Death: _____
List any medical problems that he has had:
_____
_____

Mother: Age (if living): _____ Age (at death): _____ Cause of Death: _____
List any medical problems that she has had:
_____
_____

Sister(s) / Brother(s): Ages and any medical problems he/they have had:
_____
_____

Children: Ages/Sex and any medical problems they have had:
_____
_____

3. LIFESTYLE HISTORY

A. Smoker (currently): ☐ YES / ☐ NO Number packs per day: _____
Number of years smoking: _____ If ex-smoker, when did you quit: _____

B. Alcohol intake:
What do you usually drink? _____ How much?: _____ How often? _____
I do not drink alcohol _____

C. Recreational drug use: ☐ YES / ☐ NO If yes, what? _____
What age were you when you started? If ex-user, when did you quit? _____

D. Have you had any work related illnesses/injuries? ☐ YES / ☐ NO
My Injury/Illness was: _____
While employed as: _____

Are you unable to work because of a medical injury? ☐ YES / ☐ NO

4. HEALTH MAINTENANCE

Date of last physical / annual exam: _____ Physician: _____

5. REVIEW OF SYSTEMS

A. In the past, have you been diagnosed as having any of the following conditions? **Check and date**.

SYMPTOMS	DATE	SYMPTOMS	DATE
[ ] High Blood Pressure		[ ] Varicose Veins	
[ ] Hardening of the arteries		[ ] Phlebitis	
[ ] Heart attack		[ ] Migraine headaches	
[ ] Stroke or TIA		[ ] Cluster headaches	
[ ] Heart murmur		[ ] Tension headaches	
[ ] Angina		[ ] Congestive heart failure	
[ ] Cataracts		[ ] Glaucoma	
[ ] Sinusitis		[ ] Meniere's disease	
[ ] Nasal Polyps		[ ] Allergic rhinitis	
[ ] Tonsillitis		[ ] Gum Disease	
[ ] Cervical (neck) strain		[ ] Arthritis	
[ ] Lupus		[ ] Rheumatoid arthritis	
[ ] Emphysema		[ ] Chronic bronchitis	
[ ] Pneumonia		[ ] Asthma	
[ ] Fibrocystic breast disease		[ ] Galactorrhea (breast discharge)	
[ ] Hyperthyroidism (overactive)		[ ] Hypothyroid (low thyroid)	
[ ] Pernicious anemia		[ ] Lymphoma	
[ ] Peptic ulcer		[ ] Iron deficiency anemia	
[ ] Gastritis / Esophagitis		[ ] Giardia or other parasite	
[ ] Intestinal polyps		[ ] Malabsorption	
[ ] Diverticulosis		[ ] Chronic fatigue syndrome	
[ ] Irritable bowel		[ ] Enlarged prostate	
[ ] Reflux or GERD		[ ] Crohn's disease	
[ ] Fibromyalgia		[ ] Prostatitis (prostate infection)	
[ ] Ulcerative colitis		[ ] Pelvic Inflammatory disease	
[ ] Hemorrhoids		[ ] Uterine fibroids	
[ ] Epididymitis		[ ] Cystitis (bladder infection)	
[ ] Dysmenorrhea		[ ] Hepatitis A, B or C	
[ ] Vaginitis		[ ] Diabetes	
[ ] Pyelonephritis (kidney infection)		[ ] Gallstones	
[ ] Kidney stone		[ ] PMS or PMDD	
[ ] Hypoglycemia		[ ] Depression	
[ ] Bulimia or Anorexia		[ ] Multiple sclerosis	
[ ] Any type of cancer?		[ ] Panic attacks	
What type?		[ ] High cholesterol or triglycerides	
[ ] Abnormal xray findings		[ ] Sexual dysfunction	
Describe		[ ] Abnormal PAP smear	

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B. Presently or in the past, have you had any of the following symptoms? **Check and date**.

SYMPTOMS	DATE	SYMPTOMS	DATE
[ ] Recurrent headaches		[ ] Weight loss # of pounds lost	
[ ] Fever (unexplained)		[ ] Chills	
[ ] Generalized fatigue		[ ] Generalized weakness	
[ ] Double vision		[ ] Ringing in ears	
[ ] Recurrent sinus infection		[ ] Recurrent sore throats	
[ ] Hoarseness		[ ] Neck stiffness	
[ ] Coughing up blood		[ ] Chronic cough	
[ ] Chest pressure / tightness on exertion		[ ] Chest pressure or tightness at rest	
[ ] Feeling dizzy or off-balance		[ ] Pain in legs while walking	
[ ] Change in appetite		[ ] Abdominal burning pain	
[ ] Nausea		[ ] Diarrhea	
[ ] Changes in bowel habits		[ ] Rectal bleeding	
[ ] Painful urination		[ ] Change in urinary habits	
[ ] Breast pain		[ ] Weight gain # of pounds gained	
[ ] Night sweats		[ ] Generalized body aches	
[ ] Change in vision		[ ] Change in hearing	
[ ] Frequent nosebleeds		[ ] Recurrent gum or tooth infection	
[ ] Constant sinus drainage		[ ] Trouble swallowing	
[ ] Swollen glands		[ ] Shortness of breath on exertion	
[ ] Shortness of breath while laying down		[ ] Cough up phlegm in the morning	
[ ] Feeling faint or almost passing out		[ ] Swollen ankles or feet	
[ ] Heartburn or indigestion		[ ] Abdominal cramping pain	
[ ] Vomiting		[ ] Constipation	
[ ] Blood in or on stool		[ ] Frequent or urgent urination	
[ ] Blood in urine		[ ] Vaginal discharge or odor	
[ ] Change in menstrual		[ ] Change in sexual desire	
[ ] Breast lump		[ ] Nipple discharge	
[ ] Testicular pain		[ ] Skin rash	
[ ] Easy bruising or bleeding		[ ] Changes in hair	
[ ] Trouble sleeping		[ ] Depression	
[ ] Muscle weakness or pain		[ ] Tingling in hands or feet	
[ ] Joint swelling		[ ] Testicular swelling	
[ ] Changes in skin or moles		[ ] Lumps in neck, underarms or groin	
[ ] Sensation of being too hot or too cold		[ ] Nervousness, panic	
[ ] Mood swings		[ ] Numbness	
[ ] Joint pains		[ ] Seizures or convulsions	
[ ] Head injury and loss of consciousness		[ ] Memory loss	

List any other problems not mentioned above:

_____

_____

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