



ADVANCED
INTEGRATIVE
MEDICINE

TERESE TAYLOR M.D.

DrTereseTaylor.com

Patient Intake Form

Date: _____

Gender: M / F

Patient Name: _____ Age: _____ Date of Birth: ____/____/____

Email: _____ (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: _____ Home Phone: _____

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

Name: _____ Home Phone: _____

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

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

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: _____

Patient 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):

Date: _____ Where: _____ Reasons: _____

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 he 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



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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

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Hardening of the arteries | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Cluster headaches |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tension headaches |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Meniere's disease |
| <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Allergic rhinitis |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Gum Disease |
| <input type="checkbox"/> Cervical (neck) strain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Galactorrhea (breast discharge) |
| <input type="checkbox"/> Hyperthyroidism (overactive) | <input type="checkbox"/> Hypothyroid (low thyroid) |
| <input type="checkbox"/> Pernicious anemia | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Iron deficiency anemia |
| <input type="checkbox"/> Gastritis / Esophagitis | <input type="checkbox"/> Giardia or other parasite |
| <input type="checkbox"/> Intestinal polyps | <input type="checkbox"/> Malabsorption |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Chronic fatigue syndrome |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Reflux or GERD | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Prostatitis (prostate infection) |
| <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Pelvic Inflammatory disease |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Epididymitis | <input type="checkbox"/> Cystitis (bladder infection) |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Hepatitis A, B or C |



- | | |
|--|--|
| <input type="checkbox"/> Vaginitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Pyelonephritis (kidney infection) | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> PMS or PMDD |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bulimia or Anorexia | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Any type of cancer? | <input type="checkbox"/> Panic attacks |
| What type? | <input type="checkbox"/> High cholesterol or triglycerides |
| <input type="checkbox"/> Abnormal xray findings | <input type="checkbox"/> Sexual dysfunction |
| Describe | <input type="checkbox"/> Abnormal PAP smear |

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

SYMPTOMS DATE SYMPTOMS DATE

- | | |
|---|--|
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Weight loss # of pounds lost |
| <input type="checkbox"/> Fever (unexplained) | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Generalized fatigue | <input type="checkbox"/> Generalized weakness |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Recurrent sinus infection | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Chest pressure / tightness on exertion | <input type="checkbox"/> Chest pressure or tightness at rest |
| <input type="checkbox"/> Feeling dizzy or off-balance | <input type="checkbox"/> Pain in legs while walking |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Abdominal burning pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Changes in bowel habits | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Change in urinary habits |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> Weight gain # of pounds gained |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Generalized body aches |
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Change in hearing |
| <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Recurrent gum or tooth infection |
| <input type="checkbox"/> Constant sinus drainage | <input type="checkbox"/> Trouble swallowing |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Shortness of breath on exertion |
| <input type="checkbox"/> Shortness of breath while laying down | <input type="checkbox"/> Cough up phlegm in the morning |
| <input type="checkbox"/> Feeling faint or almost passing out | <input type="checkbox"/> Swollen ankles or feet |
| <input type="checkbox"/> Heartburn or indigestion | <input type="checkbox"/> Abdominal cramping pain |



- | | |
|---|--|
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Blood in or on stool | <input type="checkbox"/> Frequent or urgent urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Vaginal discharge or odor |
| <input type="checkbox"/> Change in menstrual | <input type="checkbox"/> Change in sexual desire |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Easy bruising or bleeding | <input type="checkbox"/> Changes in hair |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Muscle weakness or pain | <input type="checkbox"/> Tingling in hands or feet |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Testicular swelling |
| <input type="checkbox"/> Changes in skin or moles | <input type="checkbox"/> Lumps in neck, underarms or groin |
| <input type="checkbox"/> Sensation of being too hot or too cold | <input type="checkbox"/> Nervousness, panic |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Joint pains | <input type="checkbox"/> Seizures or convulsions |
| <input type="checkbox"/> Head injury and loss of consciousness | <input type="checkbox"/> Memory loss |

List any other problems not mentioned above:
