ADVANCED INTEGRATIVE MEDICINE

TERESE TAYLOR M.D.

DrTereseTaylor.com

New Medical Marijuana Patient Registration Form

Date: _____

Patient Name: _____ Date of Birth: _____

Email: (legibly please): _____

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: _____

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

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

Are you using birth control? ☐ 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
- 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: _____

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

Signature: _____

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COMPLETE MEDICAL HISTORY FORM

Patient Name: _____ 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 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	

SYMPTOMS	DATE	SYMPTOMS	DATE
[ ] Vaginitis		[ ] Diabetes	
[ ] Pyelonephritis (kidney infection)		[ ] Gallstones	
[ ] Kidney stone		[ ] PMS or PMDD	
[ ] Hypoglycemia		[ ] Depression	
[ ] Bulimia or Anorexia		[ ] Multiple sclerosis	
[ ] Any type of cancer? What type?		[ ] Panic attacks	
[ ] High cholesterol or triglycerides		[ ] Abnormal xray findings	
[ ] Sexual dysfunction Describe		[ ] Abnormal PAP smear	

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

SYMPTOMS	DATE	SYMPTOMS	DATE
[} 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		[ ] Gum or tooth infection	
[ ] Constant sinus drainage		[ ] Trouble swallowing	
[ ] Swollen glands		[ ] Shortness of breath on exertion	
[ ] Shortness of breath while laying down		[ ] Morning phlegm	
[ ] Feeling faint or almost passing out		[ ] Swollen ankles or feet	
[ ] Heartburn or indigestion		[ ] Abdominal cramping pain	

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SYMPTOMS	DATE	SYMPTOMS	DATE
[ ] 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:

_____

_____