Patient Information

Name_____ Date:_____

Is this your first medical evaluation with Aven Health? YES NO

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Phone # _____ Alternate Phone # _____

Email: _____

Emergency Contact Name: _____ Phone Number: _____

(Females) Are you pregnant or planning to get pregnant? YES NO Are you breastfeeding? YES NO

MEDICAL HISTORY: Maryland requires proof of a qualifying medical condition EVERY YEAR.

Did you bring documentation that confirms you have a qualifying condition such as: Prescriptions bottles, Physician Progress Notes, or a Letter from your Doctor/Therapist/Chiropractor? YES NO Please note: Medications that reduce blood pressure and/or blood sugar cannot be used to certify you for Medical Cannabis. What did you bring?

_____

Do you have a Primary Care Provider? YES NO

If yes, Name: _____ Phone Number: _____

Please talk to your Primary Care Provider about starting Medical Cannabis.

Current Medical Conditions: _____

_____

_____

Are you allergic to any medication? YES NO If yes, what? _____

_____

What medications/dosages do you currently take? _____

_____

_____

Do you use tobacco products? YES NO If yes, How often? _____

Do you currently drink alcohol? YES NO If yes, How often? _____

Have you ever been hospitalized? YES NO If yes, please provides details and dates:

_____
_____
_____
_____

Have you ever had surgery? YES NO If yes, please provide details and dates:

_____
_____
_____
_____

Please circle any problems experienced by your immediate family:

Asthma Stroke High Blood Pressure Cancer Diabetes Seizures Substance Abuse Tuberculosis COPD

Heart Disease Kidney Disease Alcohol Abuse Mental illness Other: _____

Please check any symptoms or conditions YOU have currently:

Insomnia _____ Chest Pain_____ Heart Palpitations_____ Cough____ Fever _____

Headaches_____ Nausea/Vomiting_____ Bloody Stools____ Anxiety_____ Skin Rash_____

Chronic Pain_____ Muscle Spasms_____ Decreased Appetite____ Diarrhea_____ Heart Burn_____

Constipation_____ Seizures_____ Difficulty Swallowing____ Eye Problems____ Depression_____

Any other symptoms or conditions? _____

Have you registered with the Maryland Medical Cannabis Commission (MMCC) YES NO

If yes, what is your MMCC ID# (all CAPS, there is no letter O)

_____ - _____ - _____ - _____

Patient Signature: _____ Date: _____

Guardian/Caregiver Signature if patient is minor/unable to sign: _____
Date: _____

HIPAA Notice of Privacy Practices Acknowledgement of Receipt:

Initial here: _____ By signing this, I hereby acknowledge that I have read and understand the privacy practice notice and may obtain additional copies upon my request. This acknowledgement will be filed with my records.

Initial here: _____ I give my permission for my medical records and files to be reviewed by another medical providers working with Aven Health. I understand that this may happen if the original provider that evaluated me needs a second opinion or is not available.

********** DO NOT WRITE BELOW THIS LINE**********

I have asked the patient if he/she has any questions regarding his/her treatment with medical marijuana. I have answered those questions to the best of my ability.

Provider Signature: _____ Date:_____