Patient Intake Form

This recommendation (circle one) New – Renewal

First Name:_____ Middle Name:_____ Last Name:_____

Date of Birth:_____ Age:_____ Sex: M or F

Address:_____ City:_____ St:_____ Zip:_____

Home Phone:_____ Cell:_____ Email:_____

SS# (necessary for cannabis registry):_____

Referred by:_____

Medical Information:

Health Habits: (Circle and explain which applies to you)

Alcohol: Daily_____ Few days a week_____ Few times a month_____ Never_____

Tobacco: Daily_____ Few days a week_____ Few times a month_____ Never_____

Female patients only: Pregnant - Yes or No

Medical history:_____

Family medical history:_____

Surgical history:_____

Medications taking now (prescription or over the counter):

_____

_____

Medications Allergies or side effects:

_____

Primary Doctor:

Name:_____ Phone:_____ Fax:_____

Office location:_____

Date and reason for last visit:_____

Patient Initials:_____