Medical Cannabis Clinics of Florida

Patient Information: **Today's Date: _____**

Name: _____ **Date of Birth: _____**

Last 4 Digits of SSN: _____ **Marital Status: _____Gender: _____**

Street Address: _____

City/ State / Zip Code: _____

Phone # _____ Cell #_____

E-mail Address: _____

Which of the following **languages** can you speak and/or understand? Please circle:

English Spanish Creole French Portuguese Hindi/Urdu other _____

Ethnicity: Non- Hispanic/Latino _____ **Race** (circle) Caucasian African-American Hispanic
Hispanic/Latino_____ Indian Oriental Other_____

Employer: _____ Employer Phone No.: _____

Primary Care Physician: _____

MMJ Authorized Physician: _____
Doctor who qualified you for Medical Marijuana Program

Emergency Contact: _____ Contact Phone No.: _____

Registered Caregiver: _____ Phone No.: _____
A Registered Caregiver is a person chosen by the patient to act as their agent in obtaining their medication at the dispensary. If you feel that you need a caregiver, please contact your qualifying physician.

MY STATE APPROVED DIAGNOSIS:

□ Amyotrophic Lateral Sclerosis (ALS)	□ PTSD	□ Cancer
□ Chronic Pain	□ Crohn's Disease	□ A terminal condition
□ Epilepsy	□ Glaucoma	□ Multiple Sclerosis

□ Parkinson's Disease □ Positive for HIV or AIDS

□ Medical condition comparable to those listed above

HISTORY OF PRESENT ILLNESS:

Please describe your main problem or reason for making an appointment _____

When did symptoms begin? _____Have you been treated for this problem before? Yes No

If yes, please describe the treatment you received including dates:

_____

PAST MEDICAL HISTORY **PAST SURGICAL HISTORY** (Please list)

PROBLEM / DATE	**SURGERY/YEAR**
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS:

List all medications you are currently taking:(include non-prescription and occasionally used medicines).

Current medication	**Dosage/ Time taken**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all psychiatric medicines you have been prescribed in the past (including anti-depressants, anti-anxiety, anti-psychotics or medications used to help you sleep).

Medication Name	Dates	How long you took it	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for a mental/ psychiatric illness? If so, please list dates and hospital:

_____

_____

ALLERGIES (List any medication, food or other allergies):

Do you have a pacemaker? Yes No

I have used Cannabis (Marijuana) prior to this visit: □ Yes □ No

If **yes**, please give name of doctor, date seen and condition for which cannabis was approved

---

Have you been evaluated and denied a medical marijuana recommendation? □ Yes □ No

If **yes**, please explain _____

Negative Effects Experienced using Cannabis (if applicable):

Positive Effects Experienced using Cannabis (if applicable):

Positive outcomes I hope to achieve using Medical Cannabis:

FAMILY HISTORY:
Please use the space below to list all of your immediate family (parents, siblings, and children).
Under illnesses, please list serious illnesses or diseases, especially psychiatric/mental illness.

RELATIONSHIP	**AGE**	**ILLNESS/ CAUSE OF DEATH**
_____	____	_____
_____	____	_____
_____	____	_____

CHILDREN:

_____	____	_____
_____	____	_____
_____	____	_____

SOCIAL HISTORY

Married _____ Divorced _____ Widowed _____

Number of Children _____

Birth state and where you were raised: _____

Education Level: High School Graduate____ Some College_____ College Graduate _____

Degrees: _____

Employment Status: Employed _____Unemployed ____ Retired_____ Student_____

Smoking: Currently smoking_____ Former smoker _____ Number of years: _____Never smoked ____

Alcohol History: Never drinks _____Currently drinks _____

Alcohol: approximate drinks per week: _____

Exercise: type: _____ frequency: _____

Hobbies, interests: _____

Are you currently driving? _____

Living Arrangements: With whom do you live? _____

_____ Home

_____ Assisted living

_____ Nursing home

Is there any other information you want to make us aware of? _____

PAST MEDICAL/ FAMILY HISTORY

Please list any serious illness or ongoing medical problems since childhood. Include any surgical procedures:

Conditions	Self	Father	Mother	Siblings	G-parent	Other
Asthma						
High blood pressure						
Diabetes						
Heart disease						
Arrhythmia						
Cancer						
High cholesterol						
Stroke/ TIA						
COPD						
Chronic bronchitis						
Emphysema						
Seizures						
Dementia						
Alzheimer's disease						
Parkinson disease						
Huntington's disease						
Gastritis						
Ulcers						
Thyroid disease						
Liver disease/ Hepatitis						
HIV/ AIDS						
Sinusitis						
Kidney disease						
Head/ Brain injury						
STD						
Reflux Esophagitis						
Glaucoma						
Macular Degeneration						
Cataracts						
Headaches/ Migraine						
Miscarriages/ stillbirth						
Vertigo						
Tremors						
Multiple Sclerosis						
Birth/ Developmental Problems						
Hypoxia						
Depression						
Anxiety Disorder						
Schizophrenia						
Bipolar Disorder (Manic Depression)						
Obsessive Compulsive Disorder						
ADD/ADHD						
Learning Disability						
Post Traumatic Stress Disorder						
Other:						

REVIEW OF SYMPTOMS: Please check any of the following that pertain to you
Give dates, duration of symptoms and details when applicable.

CONSTITUTIONAL

□ Lack of energy or fatigue _____
□ Loss of appetite _____
□ Difficulty sleeping _____
  □ Awake early and can not return to sleep
  □ Have trouble falling asleep

EYES

□ Eye pain _____
□ Blurred or double vision _____
□ Sensitive to glare _____

EARS/NOSE/THROAT/NECK

□ Problems with sense of smell _____
□ Problems with taste _____
□ Problems with hearing _____
□ Uses hearing aid _____

CARDIOVASCULAR

□ Chest pain _____
  □ At rest _____
  □ With activity _____
□ Swollen ankles _____
□ Palpitations or heart racing _____
□ High blood pressure _____
□ High cholesterol _____

RESPIRATORY:

□ Cough _____
□ Asthma or wheezing _____
□ Become short of breath when walking or with activity _____

GASTROINTESTINAL:

□ Problems swallowing _____
□ Burning in chest or stomach after meals or when lying down _____
□ Constipation _____
□ Diarrhea _____
□ Change in color of stool/ black or tarry stools? _____

GENITAL/ URINARY:

□ Delayed ejaculation _____
□ Difficulty holding in urine _____
□ Difficulty maintaining an erection _____
□ Difficulty urinating _____
□ Frequent urinary tract infections _____
□ Loss of interest in sex _____
□ Need to urinate more frequently _____
□ Pain when urinating _____
□ Pain with intercourse _____
□ Trouble starting stream, dribbling or reduced stream _____

MUSCULOSKELETAL:

□ Back pain _____
□ Difficulty standing up from sitting _____
□ Neck pain _____
□ Other pain_____
□ Pain greater in the morning and decreases with activity _____
□ Stiffness or pain in joints _____

NEUROLOGICAL:

□ Confusion _____
□ Difficulty finding your way _____
□ Difficulty maintaining home _____
□ Difficulty managing finances _____
□ Difficulty speaking _____
□ Dizziness or fainting _____
□ Feels dizzy when stands up _____
□ Forgetfulness _____
□ Head trauma _____
□ Headaches or migraines _____
□ Numbness or tingling in toes and fingers _____
□ Problem with balance _____
□ Recent fall or falls frequency _____
□ Seizure or fits _____
□ Sleep problems such as loud snoring, gasping for breath, morning headaches, daytime sleepiness or leg jerking _____
□ Tremor or difficulty writing _____

PSYCHIATRIC

□ Anxious, restless ,or irritable _____
□ Crying Spells _____
□ Depression , persistent sadness or feeling blue _____
□ Difficulty concentrating _____
□ Feelings of hopelessness or worthlessness _____
□ Hallucinations _____
□ Hearing voices _____
□ Loss of pleasure in life _____
□ Paranoia _____
□ Thoughts of hurting someone else _____
□ Thoughts of suicide _____

ENDOCRINE:

□ Cold intolerance _____
□ Dry Skin _____
□ Hair loss or coarse hair _____
□ Heat intolerance _____
□ Hoarse Voice _____
□ Thyroid disease _____
□ Weight gain or loss _____

HEMATOLOGICAL:

□ Anemia or low blood sugar _____

□ Excessive bruising or bleeding _____

□ Recurrent infections or infections that will not go away _____

If you are female, please read the following carefully:

Are you pregnant or planning to become pregnant? (circle one) YES NO

Please be advised that as part of you consultation/evaluation and treatment you are responsible to avoid an accidental pregnancy. Various medications, X-rays, CAT/MRI scans are contraindicated for pregnant women and may be very dangerous.

In complete understanding of the above and certifying that all information is true to the best of your knowledge, please sign below.

_____

Patient Signature Print Name Date

Acknowledgement of Disclosure and Assumption of Risk Agreement

Medical Information Release Form (HIPAA Release Form)

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

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices.

Messages

Please call : [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Medical Marijuana Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient or the patient's parent or legal guardian if the patient is a minor must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form.

a. **The Federal Government's classification of marijuana as a Schedule I controlled substance.**

_____The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Florida, which have modified their state laws to treat marijuana as a medicine.

_____When in the possession or under the influence of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

b. **The approval and oversight status of marijuana by the Food and Drug Administration.**

_____Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of marijuana for medical use is not subject to any federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

c. **The potential for addiction.**

_____Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Dr. _____ (name of qualified physician).

d. **The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.**

_____The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of crashing, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

e. The potential side effects of medical marijuana use.

_____Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, may affect the production of sex hormones that lead to adverse effects, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

_____ I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____I agree to contact Dr. SIDDIQUI if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Dr. _____ if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

g. The risks, benefits, and drug interactions of marijuana.

_____Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

_____Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. SIDDIQUI immediately or go to the nearest emergency room.

_____ Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences. I agree to follow the directions of Dr. SIDDIQUI regarding the use of prescription

and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

_____ Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact Dr. SIDDIQUI immediately or go to the nearest emergency room if these symptoms occur.

_____ I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. SIDDIQUI if I become pregnant, try to get pregnant, or will be breastfeeding.

h. The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.

____ Cancer

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancers, including glioma.

  There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. Due to a lack of recent, high quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy-induced nausea and vomiting.
  There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer-associated anorexia-cachexia syndrome and anorexia nervosa.

____ Epilepsy

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy.

  Recent systematic reviews were unable to identify any randomized controlled trials evaluating the efficacy of cannabinoids for the treatment of epilepsy. Currently available clinical data therefore consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

____ Glaucoma

- There is limited evidence that cannabinoids are an ineffective treatment for improving intraocular pressure associated with glaucoma.

Lower intraocular pressure is a key target for glaucoma treatments. Non-randomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systemic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited. However, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular pressure. To date, those studies showing positive effects have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

____ **Positive status for human immunodeficiency virus**

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

  There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

____ **Acquired immune deficiency syndrome**

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

  There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

____ **Post-traumatic stress disorder**

- There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of posttraumatic stress disorder.

  A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived forms) and increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

____ **Amyotrophic lateral sclerosis**

- There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis.

  Two small studies investigated the effect of dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the

sample sizes were small, the duration of the studies was short, and the dose of dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

____ **Crohn's disease**

- There is insufficient evidence to support or refute the conclusion that dronabinol is an effective treatment for the symptoms of irritable bowel syndrome.

Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of inflammatory bowel diseases, including Crohn's disease.

____ **Parkinson's disease**

- There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia.

Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson's disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

____ **Multiple sclerosis**

- There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity.

Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

____ **Medical conditions of same kind or class as or comparable to the above qualifying medical conditions**

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.
- The summary is attached to this informed consent as Addendum_____.

____ **Terminal conditions diagnosed by a physician other than the qualified physician issuing the physician certification**

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.
- The summary is attached to this informed consent as Addendum_____.

____ **Chronic nonmalignant pain**

- There is substantial evidence that cannabis is an effective treatment for chronic pain in adults.

  The majority of studies on pain evaluated nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flower form provided by the National Institute on Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms.

  While the use of cannabis for the treatment of pain is supported by well-controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

i. That the patient's de-identified health information contained in the physician certification and medical marijuana use registry may be used for research purposes.

_____The Department of Health submits a data set to The Medical Marijuana Research and Education Coalition for each patient registered in the medical marijuana use registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient.

_____ I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. SIDDIQUI has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

Dr. SIDDIQUI also informed me of the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that Dr. SIDDIQUI informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

Dr. SIDDIQUI has explained the information in this consent form about the medical use of marijuana.

Patient (print name) _____

Patient signature or signature of the parent or legal guardian if the patient is a minor:

_____ Date _____

I have explained the information in this consent form about the medical use of marijuana to _____ (Print patient name).

Qualified physician signature:

_____ Date _____

Witness:

_____ Date _____

Authorization for Medical Records and Reports

Date: _____

To: _____

You, and any person associated with you, are hereby authorized to give to Center for Neuroscience or any representative thereof any and all information which may be requested regarding my physical condition and treatment rendered by you thereof, and if necessary to allow them, or any physician appointed by them, to examine and X-Ray pictures/ CT or MRI scans/ electro-diagnostics of me, or records which may have information regarding my condition or treatment.

Please Provide the Names and Phone Numbers of your physicians that you would like to have your records forwarded :

PRIMARY CARE_____

INTERNIST _____

CARDIOLOGIST_____

PODIATRIST _____

OTHER _____

Patient's Signature: _____

Print Name: _____

DOB: _____

SS #: _____

Witness' Signature: _____