CHESAPEAKE CANNABIS CERTIFICATION

Clear Form

Forms must be completed to consider if patient meets qualifications for medical cannabis treatment:

Name_____Date_____DOB_____
Address_____
City_____ State_____ Zip_____
State and Drivers License #_____
Height_____Weight_____
Phone #_____Email address_____
May we leave a message with medical information Yes ____ No ____
Primary Care Physician and phone number_____

Reason for cannabis treatment (check all that apply)

- ☐ Severe or chronic pain
- ☐ Cachexia/anorexia/wasting syndrome
- ☐ Severe nausea
- ☐ Seizures
- ☐ Severe or persistent muscle spasms
- ☐ Glaucoma
- ☐ Post traumatic stress disorder
- ☐ Other chronic medical condition which is severe, and for which other treatments have been ineffective

Please list symptoms you experience, frequency, severity and duration

Symptom	Frequency	Severity	Duration
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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Please list all treatments you've tried, how long was each treatment attempted, and outcomes of each treatment

TREATMENT	DURATION	OUTCOME
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Do you smoke cigarettes? Yes ◯ No ◯ If so, packs per day___ how many years___

Do you drink alcohol? Yes ◯ No ◯ If so, drinks per day ___ how often___

Do you use illegal drugs? Yes ◯ No ◯ If so, type_____how often____

PAST MEDICAL HISTORY:

Diabetes	Yes ◯ No ◯	Arthritis	Yes ◯ No ◯
Hypertension	Yes ◯ No ◯	Headaches	Yes ◯ No ◯
Cancer	Yes ◯ No ◯	Multiple sclerosis	Yes ◯ No ◯
Stroke	Yes ◯ No ◯	Seizures/Epilepsy	Yes ◯ No ◯
Heart trouble	Yes ◯ No ◯	Parkinson's	Yes ◯ No ◯

OTHER MEDICAL CONDITIONS:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

PRIOR HOSPITALIZATIONS/SURGERIES:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

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MEDICATIONS with dose and frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any allergies to medications: _____

FAMILY MEDICAL HISTORY:

Any family history of addiction? Yes ◯ No ◯ If so, who? _____

	Age	Gender	Medical condition	If deceased, cause of death
Father	____		_____	_____
Mother	____		_____	_____
Siblings	____	____	_____	_____
	____	____	_____	_____
	____	____	_____	_____
Children	____	____	_____	_____
	____	____	_____	_____
	____	____	_____	_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____