Florida Medical Marijuana Institute

Adult New Patient Intake History

Pt. Name:_____ DOB:_____
Marital Status: Married Divorced Single-Never Married

Patient Health History

Date of Last Exam: _____ Results:_____

Any Serious short or long-term illness: No Yes If yes, what and when?_____

_____

Any Operations or Hospitalizations?: No Yes If yes, what and when?_____

_____

Does and Family Member Smoke: No Yes If yes, who?_____ In the Home? No Yes

Any Medication Allergies?: No Yes If yes, what med and what was the reaction? _____

_____

_____

Any History or Difficulty With any of the Following: (Circle Yes or No)

Yes No AIDS/HIV	Yes No Chicken Pox	Yes No Hearing Problems	Yes No Pneumonia
Yes No Anemia	Yes No Constipation	Yes No Heart Problems	Yes No Rheumatic Fever
Yes No Asthma	Yes No Convulsion	Yes No Hepatitis	Yes No Sinus Problem
Yes No Bed Wetting	Yes No Diabetes	Yes No Kidney Disease	Yes No Speech Problems
Yes No Birth Defects	Yes No Diarrhea	Yes No Lead Poisoning	Yes No Thyroid Disease
Yes No Bladder Problems	Yes No Drug/Alcohol Abuse	Yes No Liver Disease	Yes No Tuberculosis
Yes No Bleeding Excessive	Yes No Ear Infection	Yes No Measles	Yes No Urinary Disease
Yes No Cancer	Yes No Epilepsy	Yes No Mononucleosis	Yes No Vision Problem's
Yes No Cerebral Palsy	Yes No Fainting	Yes No Mumps	Yes No Other_____

Name of Person Completing Form: _____ Relationship to Patient: _____ Date:_____