Holos Health Medical Cannabis Evaluation

Date:________________
Name: First____________________MI________________Last________________________________
Social Security Number________________________________ (Please provide for state application)
Date of Birth________________ Phone #___________________ Email_________________________
Mailing Address:____
Have you ever had a Colorado MMJ license? YES NO Is your license current? YES NO
Have you been seen at Holos Health in the past? YES NO
If this is a renewal and you have not seen us in the past, can you recall where you went for your previous MMJ recommendation? ____
How did you hear about us? ____
Do you have medical insurance? YES NO If so, what company_________________________
Do you have a primary care practitioner? YES NO If so, who?________________________
Would you like a superbill to submit to your insurance for reimbursement? YES NO
Medical indication(s) for the use of medical cannabis: ____
____
____
____
Do you have access to medical records pertaining to the indicated condition(s)? YES NO
Did you bring medical records to your visit today? YES NO
Please list all other medical conditions: ____
____
Hospital admissions or surgeries: ____
____
Current medications:
____
____
Medication/other allergies:____
____
Are you currently using cannabis? _______ If so, what methods and times per day/week?:
Smoke: bud_____________________________ concentrates______________________________
Vaporize: bud____________ concentrates: _____________ Dabs: __________________________
Edible: ______________ Tincture: _________________ Transdermal patch or cream: __________
Topicals: _____________ Juicing:_________________
Other:____
Do you grow any of your own plants? ___________ Do you have a private caregiver? _____________
Do you have a preferred dispensary? If so, which one? _____________________________________
Do you use tobacco? YES NO
Do you have a safe place to keep MMJ away from minors? __________________________________
Do you use, or have a history of abuse, of alcohol or any other drugs (prescription or other)?
please explain: ____
____

Do you have any history of mental health issues such as PTSD, bipolar, psychosis, depression or anxiety? If so, please explain ____

____

Do you have a family history of any the following? If so, please elaborate:
Cancer, cardio-vascular disease, autoimmune disease, diabetes, genetic disorder, gluten sensitivity or celiac, other: ____

____

____

Please write a brief description of your eating habits including any food limitations or special diet:

____

____

Do you exercise? YES NO If so, what type and how often? __________________________

____

FOR THOSE WITH SEVERE PAIN AS THEIR INDICATION:

Specify the areas of your pain ____

Rate the intensity of your pain from 1-10 ______ (10 being most severe)

What other treatments have you tried for your pain? _______________________________________

____

____

FOR THOSE WITH A CANCER DIAGNOSIS:

Type and stage of cancer:____

Forms of treatment (chemo, radiation, surgery, etc.) _______________________________________

____

____

____

____

Do you want to use cannabis for treating symptoms, as a potential chemotherapy agent or both?

____

____

OTHER CONDITIONS FOR WHICH YOU WOULD LIKE TO ELABORATE:

Please state medical condition and give details:_____________________________________

____

____

Any other specific issues you would like to address today?

____

____

FOR OUR LADIES:

Are you currently breast-feeding, pregnant or planning a pregnancy soon?

____

Are you menopausal? YES NO If so, do you want to discuss hormone replacement therapy with one of our doctors or our nurse practitioner? YES NO

Date of last menstrual period ______________________

If using contraception, what method? ____