

MEDICAL CANNABIS OR SOUTHERN CALIFORNIA

Annual Renewal Form for MCSocal Patients

Name _____ Date _____

Since your last visit have you changed your address? Phone Numbers? Email address? Yes ____ No ____

If yes to any please update our records:

Are you currently on probation? ____ or parole? ____

In the past 12 months:

1) Has your medical history changed (i.e. received a new diagnosis, changed medications, MRI's CT Scans, X-Rays)? Yes ____ No ____

If yes please specify: _____

2) Have you visited your primary care physician? Yes ____ No ____

If yes specify date, physician's name/address and reason for visit:

3) Have you been hospitalized for any reason (surgery or illness)? Yes ____ No: ____

If yes specify date, hospital and reason for hospitalization: _____

4) Have you been evaluated by a specialist (i.e. Neurologist, Pain Specialist)? Yes ____ No ____

If yes specify date, physician and reason for visit: _____

5) Have you started taking any new medication? Yes ____ No ____

If yes please specify: _____

6) Have your drinking, drug use, or cigarette smoking habits changed? Yes ____ No ____
If yes please specify: _____

7) Are you renewing your cannabis recommendation for the same diagnosis/symptom as last year?
Yes ____ No ____
If yes what is your diagnosis: _____
If no, please specify the exact reason you are seeking a cannabis recommendation:

8) On average, how often did you medicate with cannabis? _____

Did you primarily Vaporize? ____ Edibles? ____ Topical? ____ Smoke ____

9) Did cannabis help relieve your symptoms? Yes ____ No ____

If yes, please describe how cannabis helped you (i.e. "Less Pain" "Improved Sleep" "Relieved anxiety")

Physicians Comments (leave blank)

Patient Signature _____

Date ____ / ____ / ____

Physicians Signature _____
Sean P. Breen D.O. CA 20A8273 DEA# FB0937500

Date ____ / ____ / ____