MEDICAL CANNABIS OF SOUTHERN CALIFORNIA

New Patient History

(A) PATIENT INFORMATION:

Name _____ Date_____/_____/_____

Address _____

City_____ State _____ Zip _____

Home phone:_____ Cell phone: _____

Age_____ Email: _____

Do we have permission to send you a reminder to renew your medical recommendation in 12 months?
No_____ Yes _____ (Email Only_____ Phone Only _____ Both _____)

How did you hear about Medical Cannabis of Southern California?(check all that apply)
Google ___
Press Telegram ___
Beach Comber ___
CaNorml.org ___
MCC Directory ___
Referral ___ Please Specify By Who _____

Other (specify)_____

Is this your first evaluation for medical cannabis? Yes ___ No ___

Are you currently on probation? ___ or parole? ___

(B) PAST MEDICAL HISTORY

Name of your doctor that diagnosed or treated you for the condition you are seeking a recommendation for:

_____

Name Address City State Zip

_____

Phone/Fax

Approximate date (month/year) of the last time you were seen by this doctor:_____

MEDICAL CONDITIONS: Please list **ANY** medical condition that you have been diagnosed with or received medical care for (For example: Chronic Pain, HIV, Anxiety, Depression, Insomnia, High Blood Pressure, Heart Attack, Irritable Bowel, Seizures, Stroke, Migraines, Crohns Disease, GERD, Sinusitis, Asthma, Pneumonia, Cancer, Anorexia, Hypothyroidism, Fibromyalgia, High Cholesterol, Diabetes, Obesity, Pancreatitis, Plantar Fasciitis, ADHD etc.)

_____
_____
_____
_____

(C) PAST SURGICAL HISTORY

Please list any surgeries that you have had in the past. Include the reason, date, hospital and doctor who performed the surgery _____

_____

Are you allergic to any medications? Yes _____ No _____ If yes please list your drug allergies below:
_____

(D) CURRENT MEDICATIONS:

Please list the medications that you're currently taking on a daily or occasional basis (please include over the counter medications such as Claritin): Include the dosage and frequency of use.

_____

_____

FEMALES ONLY: Are you currently using birth control? No____ Yes ____ Specify _____
Are you currently pregnant? No ____ Yes ____
Are you currently breast feeding? No ____ Yes ____

(E) SOCIAL HISTORY

How often do you drink alcohol and how many drinks do you typically consume when you drink? (For example: Typically drink 6-10 drinks every weekend)_____

How often do you use any recreational drugs other than marijuana and what do you use? (Heroin, Cocaine, Ecstasy, Acid, Mushrooms etc.)_____

How often do you smoke cigarettes and how many do you smoke each day? _____

(G) CHIEF COMPLAINT

Please describe the medical condition or complaint that you are seeking a recommendation for medical marijuana: (please include when you first noticed the symptoms and when you received the diagnosis)

_____

_____

_____

_____

Do you currently use cannabis to treat your current medical condition? Yes ___ No ___
If yes: How long have you been using cannabis? _____
Have you used cannabis recreationally in the past? Yes ____ No ____ If yes How Long? _____
Have you ever had any allergic reaction to cannabis in the past Yes ____ No ____
Does it provide relief for your symptoms? (if yes please describe. For example, less pain or nausea)

_____
How often do you use it (daily, weekly, monthly)_____
How much cannabis do you consume per treatment?_____
What method do you currently use to consume the cannabis (Ingest/Vaporize/Smoke?) _____

If not listed above, please describe all treatments that you have received to date for your current medical problems such as the medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, chiropractic care or other:

_____

Physicians Comment (leave blank)

_____

_____

_____

Past Tx:_____

_____
ADA Criteria Work?____ Sleep____ Eat____ Interact w/ Others____ Bodily Function_____

Patient Signature _____ Date ___/____/_____

Physicians Signature_____ Date ____/___/_____
Sean P. Breen D.O. CA 20A8273

Dr. Sean Breen, PC
DBA: Medical Cannabis of Southern California (MCSoCal)
Informed Consent, Release of Liability and Patient Acknowledgement

Please Initial Next to Each One:

_____ I understand that I must be a California Resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under California's Compassionate Use Act of 1996 (Health and Safety Code #11362.5).

_____ I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis provides substantial relief and improvement in my condition.

_____ I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminates. In requesting an approval or recommendation for the use of this plant as medication I assume full responsibility for any and all risks of this action.

_____ I am advised that the cannabis smoke contains chemicals known as tars that may be harmful to my health. Recent research indicated that vaporizing cannabis might eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to a physician.

_____ I am advised that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

_____ California's Compassionate Use Act of 1996 (health and Safety Code #11362.5) provides for the possession and cultivation of cannabis for the personal medical purposes of a patient with physician approval or recommendation. It should be made absolutely clear that the physician, staff, management and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity to my obtaining cannabis.

_____ I, the undersigned, hereby request a consultation by a physician for purposes of determining the appropriateness of medical cannabis treatment. There are no claims about the medical efficacy of cannabis. The physician, staff, management and representatives of this practice are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care provider. Should an approval be made for my medical use of cannabis, I understand that there is an expiration of this approval at a date specified by the physician.

_____ I understand that is is my responsibility to see a physician to assess the possible continuance of cannabis use beyond the approval expiration date. Furthermore, I, the undersigned, my heirs, or anyone acting on my behalf, hold the physician and his/her principals, agents, employees and management harmless and free from any liability resulting from the use of cannabis.

_____ If anything changes with my medical condition, I will notify Medical Cannabis of Southern California immediately.

_____ I understand that Medical Cannabis of Southern California may be contacted to verify the information contained in my physician's letter of recommendation. I hereby authorize the staff of Medical Cannabis of Southern California to discuss my medical condition an the contents of my physicians letter of recommendation for verification purposes.

_____ I understand the cultivation, distribution, possession, and use of marijuana is federally illegal. The federal government has classified marijuana as a Schedule I controlled substance. Scheduled I substances are defined, in pat, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the U.S.; (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in the states, such as California, which have modified their state laws to treat marijuana as medicine.

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_____ I understand that potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low or high blood pressure, impairment of short-term memory, memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, 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 marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment.

_____ I agree to contact MCSOCAL 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 MCSOCAL if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin too withdraw from my family and/or friends.

_____ I understand that the risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treatment physician(s).

_____ I understand that individuals may develop a tolerance to, and/or dependence on, 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 will contact the physician at MCSOCAL

_____ I understand that signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness

_____ I understand that 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 the physician at MCSOCAL immediately or go to the nearest emergency room.

_____ If the physician or staff at MCSOCAL subsequently learn that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with the physician at MCSOCAL and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided

_____ 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 and represent that I am a resident of California. I acknowledge and represent that I am over 21 years of age, or that I am over 18 years of age with an accompanying parent. I acknowledge and represent that I am not an agent of law enforcement, state or federal government, here for the purpose of investigation or entrapment. I acknowledge and represent that I am not recording any portion of my visit with MCSOCAL nor do I possess any recording equipment. I understand MCSOCAL does not approve such action

Signed: _____ Date: _____

Print Name: _____