PATIENTS fill this out and return to us.

Medical History — Initial Evaluation Form

Basic information

Patient name: _____ Birthdate: _____

Main phone: _____ Email: _____

Address: _____

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Occupation: _____ Employer: _____

❑ Male ❑ Female ❑ Height: _____ Weight: _____

Married (spouse's name: _____) ❑ Single

Emergency contact name: _____

Relationship: _____ Phone: _____

Qualifying information

Certification for legal marijuana use requires verification of a qualifying condition. Please check what qualifying symptoms or disease apply.

- ❑ Pain for at least 6 months
- ❑ Severe nausea
- ❑ Seizures
- ❑ Severe muscle spasms
- ❑ Wasting syndromes (weight loss)
- ❑ Inflammatory bowel disease
- ❑ Cancer
- ❑ Glaucoma
- ❑ HIV or AIDS
- ❑ Hepatitis C
- ❑ ALS (Lou Gehrig's disease)
- ❑ Alzheimer's disease
- ❑ Nail patella syndrome
- ❑ Post traumatic stress disorder

Are you currently a legal resident of Maine?
❑ Yes ❑ No

Are you able to provide prior medical records as confirmation of your condition?
❑ Yes ❑ No

Please turn over for page 2.

Further medical information

Known medication allergies: ❑ None ❑ Yes (please list below)

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_____

Current medications: ❑ None ❑ Yes (please list below)

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Other medical history: ❑ None ❑ Yes (please list below)

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