



PATIENT QUESTIONNAIRE

Personal Information – please include all requested information

Date _____

Name _____ Date of Birth* _____ Age _____

Address* _____

City _____ State _____ Zip* _____

Home Phone _____ Cell phone* _____ Work phone _____

E-mail address* _____ SSN*: _____ - _____ - _____

*required information

Medical History - you must enter information here.

Current Medical complaint: (List the medical problems for which you use or would like to use medical Cannabis; include year of onset of symptoms.)

Please list all of your current medications:

Please list any medication allergies:

Primary Care Provider: Please give the name and address of your health care provider

Name _____

Address* _____

City _____ State _____ Zip _____

Fax number* _____ Work phone* _____

E-mail address _____

*required information

Do you have or have you ever had any of the following medical problems?

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___ Asthma/Lung Disease	___ Cancer
___ HIV/AIDS	___ Diabetes
___ Hepatitis	___ Epilepsy/Seizures
___ Stroke	___ Liver Disease
___ Kidney Disease	___ High Blood Pressure
___ Heart Disease	___ Sleep Disorders (sleep apnea, insomnia)
___ Substance Abuse	___ Intestinal Disorders (IBS, Ulcerative Colitis, Crohn's)
___ Multiple Sclerosis	___ Psychiatric Disorders

Cannabis History

How often do you use Cannabis? _____

How much Cannabis do you use? (puffs per day, grams per day, or ounces per month) _____

How many times a day do you use Cannabis? _____

Do you use Cannabis to reduce or eliminate the use of any medications that have been prescribed for your medical condition? _____ If yes, which medication have you reduced or eliminated?

Additional Information

Do you have an open court case regarding Cannabis? _____ Are you currently on probation? _____

Please provide any additional information that may be relevant to the physician evaluation:

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Patient's Signature _____

Date _____

Print Name _____



PATIENT ACKNOWLEDGEMENT

I understand that:

The attending physician, staff and/or representatives are neither providing, dispensing nor encouraging me to obtain or use medical Cannabis.

The attending physician, staff and/or representatives will not be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain Cannabis.

The physician, staff and representatives are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the physician. **It is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.**

I acknowledge that I am a resident of The Commonwealth of Massachusetts and have not misrepresented any information herein.

I acknowledge that I am not an agent of law enforcement, State or Federal government here for the purpose of investigation or entrapment.

I acknowledge that I am not recording any portion of my visit.

I acknowledge that it is up to me to become a patient of Inhale MD Health & Wellness. If I decide not to be a patient I am fully responsible for the cost of the evaluation. There will be no refunds.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Inhale MD Health & Wellness to disclose and verify my records as a patient to a Cannabis dispensary for the purpose of obtaining Cannabis. I understand that this authorization is valid for the period of time for which the recommendation for Cannabis has been issued.

I hereby authorize Inhale MD Health & Wellness to disclose my medical records and recommendations to my other health care providers, without limitation, in accordance with general medical practice and HIPAA.

I hereby authorize the use and disclosure of my patient records, except for personal identifying information, for use in data analysis of cannabis-treated patients

I hereby authorize Inhale MD Health & Wellness to disclose and verify my medical records to law enforcement should I be arrested or detained related to my possession or use of Cannabis. I understand that you will only provide verification of my patient status for the purpose of providing proof to justify my possession of Cannabis. I understand that this authorization is valid for the period of time for which the recommendation for Cannabis has been issued.

INFORMED CONSENT

I am being evaluated for a physician's certification that I meet the criteria set forth in Massachusetts State law for medical Cannabis. The physician will make this certification based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use Cannabis only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is **my responsibility** to be informed regarding state and federal laws regarding the possession, use, growing of, sale/purchase and/or distribution of Cannabis.

I have been informed of and understand the following: [please initial at the bottom of the page]

1. I must be a Massachusetts resident to obtain an approval of recommendation for the use of cannabis.
2. The federal government has classified Cannabis as a Schedule I controlled substance. Schedule 1 substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of Cannabis even in medically legal states which have modified their state laws to treat Cannabis as a medicine.

Initials: _____

3. Cannabis has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the "manufacture" of Cannabis for medical use is not subject to any standards, quality control, or other oversight. Cannabis

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may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to Delta 9 THC, which is the primary psychoactive chemical component of Cannabis.

4. The use of Cannabis can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using Cannabis, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of Cannabis, I can be arrested for “driving under the influence”.

5. Potential side effects from the use of Cannabis include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term 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. Cannabis may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of Cannabis may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment.

6. I understand that using Cannabis while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and Cannabis.

7. I agree to contact Inhale MD Health & Wellness 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 Inhale MD Health & Wellness if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends. If I cannot reach Inhale MD Health & Wellness I will go to the nearest Emergency Room to seek treatment.

8. Smoking Cannabis may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, Cannabis smoke contains known carcinogens (chemicals that can cause cancer) and smoking Cannabis may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. In addition, Cannabis smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using Cannabis, I will stop using it and report my symptoms to a physician.

9. The risks, benefits and drug interactions of Cannabis 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 Cannabis and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

10. Individuals may develop a tolerance to, and/or dependence on, Cannabis. 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 Cannabis, I should contact Inhale MD Health & Wellness or seek treatment with my primary care MD or addiction medicine specialist.

11. Psychological signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

12. Symptoms of Cannabis 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 immediately go to the nearest emergency room.

13. If Inhale MD Health & Wellness subsequently learns that the information I have furnished is false or misleading, the recommendation for Cannabis may no longer be valid and that the Department of Public Health will receive notice of this fraudulent behavior. I agree to promptly meet with Inhale MD Health & Wellness and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

14. I have had, or will have, 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 that the physician has not provided a recommended treatment of my condition with medical Cannabis. The physician did inform me of the risks, complications of any recommended treatment I choose to undertake under my own judgment (under the laws of the Commonwealth of MA) after obtaining the certificate. I acknowledge the physician has, informed me of any alternatives to medical Cannabis that I may pursue with other members of my health care team.

Patient Signature: _____

Date: _____



“Mass Legal requirement per 105 CMR 725.000: IMPLEMENTATION OF AN ACT FOR THE HUMANITARIAN MEDICAL USE OF MARIJUANA

725.010: Certifying Physician’s Written Certification of a Debilitating Medical Condition for a Qualifying Patient

1. Such program must explain the proper use of marijuana, including side effects, dosage, and contraindications, including with psychotropic drugs, as well as on substance abuse recognition, diagnosis, and treatment related to marijuana.”

Inhale MD Health & Wellness is providing you with this listing of the common concerns from the medical community regarding cannabis to try and meet part of this requirement despite limited to no traditional clinical trials:

General Remarks: Deaths due to cannabis use are not known. The median lethal dose in rats was 800 to 1,900 mg (depending on strain) oral THC per kilogram body weight. In studies with monkeys no deaths were recorded following the highest applied doses of 9,000 mg/kg oral THC. All possible side effects are dose dependent. Therapy should always start with low doses, slowly increasing, so that the individual dose can be determined and unwanted effects can be avoided.

Acute side effects: Known psychic side effects are sedation, euphoria high, dysphoria, fear of death, feeling out of control, impairment of memory, altered time perception, depression, hallucinations. In case of strong psychic side effects the affected should be brought to a calm place and “talked down”. Cognition and psychomotor performance are attenuated. A discrete reduction of psychomotor performance may be observed up to 24 hours after the administration of THC.

Frequent acute physical side effects are dry mouth, movement disorder, muscle weakness, slurred speech, increase of heart rate, decrease of blood pressure in vertical position, eventually with dizziness. In case of dizziness the affected should lie down. In horizontal position a slightly higher blood pressure may be measured. Rare side effects are nausea and headaches.

All acute side effects are dose dependent and generally disappear within hours or 1-3 days without specific treatment.

Side effects of long-term therapy: Development of tolerance is described for a multitude of effects, among them psychic actions, psychomotor impairment, effects on heart and circulation, effects on the hormonal system, intra-ocular pressure, and anti-emetic effects. Tolerance means that the effects decrease with time during use of cannabis. Tolerance may appear with repeated doses within weeks with different extent for different effects.

Cannabis possesses a potential for addiction. Dependency may not be a relevant problem within the bounds of therapy of diseases, but withdrawal may be unwanted. Withdrawal has not been described in patients that were long-term treated with THC. But withdrawal has been observed in recreational users. Thereby psychic symptoms (anxiety, restlessness, insomnia) and physical symptoms (salivation, diarrhea) may occur.

The course of a psychosis may be influenced unfavorably. In vulnerable persons the onset of a psychosis may be accelerated or triggered.

Cannabinoids may exert complex effects on male and female sex hormones, their clinical relevance in therapeutic doses being low. Occasionally menstrual cycles without ovulation and impairment of sperm production have been described. In animal studies high doses of THC suppress several aspects of the immune system. In low doses immunosuppressing as well as immunostimulating have been ascertained. Cannabis does not accelerate the progression of HIV/AIDS; however, a chronic administration of THC may be unfavorable in otherwise immunocompromised individuals.

This is a common form used nationwide by doctors to educate their Medical Cannabis. Sign below that you have read this document. You may ask questions during your visit. You should keep this document for reference. Inhale MD Health & Wellness will add your signed copy to your medical record.

Patient Signature: _____