14689 Garrett Highway, Oakland, MD 21550
Phone: 301-334-5610 | Fax: 888-843-8457

Patient Medical History Form *To be completed by the patient*

Name_______________________________DOB____________________

Address____

City____________________________State_________Zip____________

Phone_______________________Email__________________________

Medical diagnosis for which seeking treatment with medical cannabis

Check one or more conditions:

____ Severe or Chronic Pain

____ Severe Nausea

____ Loss of appetite

____ Seizure Disorder

____ Glaucoma

____ PTSD

____ Any severe condition for which other medical treatments have been ineffective and medical cannabis can be expected to help with symptom relief

Past medical history Check conditions that apply and write any other medical

____ Coronary artery disease/Heart attack

____ Stroke/TIA

____ Peripheral vascular disease

____ COPD

____ Asthma

____ Deep venous thrombosis/Pulmonary Embolism

____ Diabetes

____ Aortic Aneurysm

____ Congestive Heart Failure

____ Atrial Fibrillation

____ Cardiac Arrest

____ High blood pressure

____ Active or previous alcohol or drug abuse

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Other Medical Conditions:

Current Medications:

Medication/Food Allergies:

Surgical Procedures:

BROOKSIDE HEALTH & WELLNESS
RACHEL FRIEND-LANTZ, CRNP

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Patient Name: ____ Date: __________________

NIDA *Quick Screen* Question: <u>In the past year</u>, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

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I, ___________________(patient name) on _____________ (date) understand and agree to the following statements and will promise to adhere to the written statements I have signed.

I understand the potential risks of using medical cannabis including but not limited to addiction and potential cardiopulmonary complications.

For women, I promise that I will not use medical cannabis if I am currently pregnant, become pregnant or breastfeeding and I will monitor for pregnancy at least monthly if currently sexually active and currently capable of becoming pregnant.

I promise to use my access to medical cannabis for treatment of my medical condition only and will not give away or sell medical cannabis obtained using my medical cannabis card.

Patient Signature:____

Witness Signature: ____

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HIPAA Compliance Patient Consent Form

In the process of providing thorough medical care, Maryland Cannabis Physicians staff collects and retains medical information for which the upmost respect is taken to keep this information private. Our clinic has taken steps in accordance with Federal and State laws to protect the confidentiality of our patient's protected medical information. Personal information will only be released to people who have been authorized by the patient and listed on their HIPPA form. In addition, we follow the Federal and State laws regarding disclosure of private medical information. You ascertain that by your signature that you have reviewed our notice before signing this consent. You have the right to restrict how your protected health information is used and disclosed for treatment.

By signing this form, you consent to our use and disclosure of your protected healthcare information.
By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

____

____

____

This consent was signed by: ____ (PRINT NAME)
Signature: ____ Date: __________________
Witness: ____ Date: __________________

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Primary Care Provider:_______________________ Patient Name: ___________________________________

Date of Birth: ___________________________________

Your patient has requested a consultation from one of our providers at Brookside Health and Wellness, LLC. Could you please fax back the **last 3 office notes related to the condition listed below including**:

- **Relevant Primary care providers progress notes**
- **Specialist consultation notes**
- **Imaging tests**

Thank you for your cooperation and your time. Have a wonderful day!

Reason for Consultation:

I do hereby consent and authorize the release of my medical records to Brookside Health and Wellness, LLC for the purpose of evaluation for medical cannabis eligibility.

Patient Name: ____Date:_________________

Signature: ____