RENEWAL QUESTIONNAIRE

Last Name_______________________ **First Name**___________________ **Age** ______ **DOB**_______**Date**_______

Address: _________________________________ **Apt.** _____ **City** ____________________________ **Zip** ___________

Email: ________________________ **Phone:** ________________________ **Cell:** ______________________________

Welcome Back to Compassionate Health! Below is a brief questionnaire regarding your health in the past year, as compared to when you last visited us. Thank you!

Please check the problems or conditions for which you are seeking an evaluation:

- ☐ Chronic Pain
- ☐ Insomnia
- ☐ Headache
- ☐ Muscle Spasm
- ☐ Anxiety
- ☐ Depression
- ☐ Anorexia
- ☐ Glaucoma
- ☐ Nausea
- ☐ Other ___________

When was your last visit to a doctor? ______________**Do you have health insurance?** ____________________

What was the visit for?____

Has your health changed since your last visit? If yes, how? ____

____

Current/Previous Medications (include herbs, OTC meds. etc.)

Medications & Dosage	Side Effects	Pharmacy	Date Filled	RX#

Do you smoke cigarettes? If so, how many per day? _____________

Do you use alcohol? If so, how many drinks per day? ____________

Do you feel that you observe a healthy diet? YES NO

Are you currently pregnant or nursing? YES NO

Do you exercise regularly? YES NO If yes, how? ____

What is your preferred method of using cannabis? Smoking Vaporizer Edibles Tinctures Topical

How often do you use marijuana?______________ **How much marijuana do you use in 1 week:** ___________

Please describe how cannabis relieves your symptoms and/or conditions? _____________________________

____

Who do you currently live with, and has your living situation changed in the past year?

____

Employment:

☐ Employed: Occupation___________________________ ☐ Volunteer ☐ Retired ☐ Unemployed

☐ Student (Where?) __________________________ ☐ Disabled ☐ Worker's Comp

Any other questions or issues you would like to discuss with the doctor? Please describe:

____

FOR STAFF USE ONLY **Last Name**_____________________ **First Name**____________________

B/P	**Pulse**	**HT**	**WT**	**LNMP**	**G P**
☐ **Normal organ system**					**Abnormal findings**

General:	☐ well developed/well nourished – alert
Skin:	☐ intact…warm…dry…well hydrated…no rashes
HEENT:	☐ External inspection nml…
Neck:	☐ Non-tender – ROM w/o pain – no palpable masses
Resp:	☐ nml resp. effort & excursion – breath sounds nml/equal/clear
CVS/chest:	☐ RRR – no M/G/R – nml s1/s2
GI:	☐ non distended – non-tender – no masses – no guarding – no rebound
Back:	☐ no vertebral tenderness – no CVAT
Hips/Pelvis:	☐ FROM … non-tender
Extremities:	☐ FROM …normal extremities:
Neuro:	☐ CN II-XII intact…DTR's symmetric…sensory nml…motor symmetric/ wnl…leg raise neg.
Psych/MiniMental status:	☐ oriented x 3…mood appropriate…judgment good…nonsuicidal Done if needed: Date, place, register 3 Objects, Serial Sevens, Recall 3 Objects, etc.
Notes	
Assessment	
Plan	

☐ Pt. to f/u with PMD for management, update of mental/physical conditions.
☐ Vaporizer/edibles etc. ☐ R&B discussed ☐ Medical Record release

Cannabis approval for:

☐ 2 months ☐ 3 months ☐ 6 months ☐ 1 Year ☐Other ______/______/_______

Diagnosis: ____

Comments: ____

Physician's Signature ______________________________ **Date**_________________