PDI MEDICAL, LLC
MEDICAL MARIJUANA PATIENT INTAKE FORM

Patient Information (Please Print)	
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Married / Divorced / Widowed	
First name: **Last name:**	
Birth date: (mm/dd/yyyy) / / Sex: ❑ M ❑ F	
Street address:	Can we text you? Cell Carrier? ❑ yes ❑ no _____
	Cell phone # ( )
City:	Home phone # ( )
State: ZIP Code:	Opt out to receive mass Marketing from BioTrack THC? ❑ no ❑ yes
Preferred E-mail address:	

Choose your condition(s) (The 39 conditions approved by Illinois as of 12/10/15)

❑AIDS ❑Agitation of Alzheimer's ❑ALS ❑Arnold-Chiari malformation
❑Cachexia/wasting syndrome ❑Causalgia ❑CID polyneuropathy ❑CRPS ❑Crohn's
❑Dystonia ❑Fibromyalgia(severe) ❑ Fibrous dysplasia ❑Glaucoma
❑Hepatitis C ❑HIV ❑Hydrocephalus ❑Hydromyelia ❑Interstitial cystitis ❑Lupus
❑MS ❑MD ❑Myasthenia Gravis ❑Myoclonus
❑Nail-patella syndrome ❑Neurofibromatosis ❑Parkinson's ❑PTSD ❑RSD ❑Residual limb pain ❑RA
❑Seizures ❑Sjogren's syndrome ❑Spinal cord disease ❑Spinal cord injury ❑SCA ❑Syringomyelia
❑Tarlov cysts ❑Terminal Illness (type)_____
❑Tourette's syndrome ❑Traumatic brain injury (TBI) & post-concussion syndrome
❑Cancer (type)_____

Reason I chose PDI Medical or/ Referred to our dispensary by (please check boxes that may apply):

❑ MD (name)_____
❑ Family ❑ Friend ❑ Closest dispensary to home/work ❑ Hospital
❑ Facebook ❑ LinkedIn ❑ Twitter ❑Google +
❑ Website (which one?) _____
❑ Other?

Any other comments:

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Health Habits Background
(Provide No Or Yes To Every Question)

Consume Alcohol? ❑ no ❑ yes # drinks per week_____

Smoke/ Chew Tobacco? ❑ no ❑ yes # cigs per day_____ qty of chew per day_____

Any form of regular exercise? ❑ no ❑ yes # of times per week_____

What is that exercise? _____

Daily Diet Intake? ❑ 3 meals a day ❑ 2 meals a day ❑ 1 meal a day ❑No appetite (eat when can)
(optional) ❑Variety--- meats/vegetables/fruits/grains/milk products
❑Variety with restrictions _____
❑Vegetarian
Snacks throughout day? ❑ no ❑ yes
What type? ❑ nutritious (e.g., juice/fruit/veg/nuts) ❑non-nutritious (chips/soft drinks)

If female, pregnant ❑ no ❑ yes

Family Medical History (if known)

Parents (either one):
Diagnosed Conditions:
❑ High blood pressure ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Cancer ❑ Crohn's disease
❑ Alzheimer's disease ❑ Multiple sclerosis ❑ Rheumatoid arthritis ❑ Stroke ❑ Heart disease
❑ Other? _____

Siblings (either one):
Diagnosed Conditions:
❑ High blood pressure ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Cancer ❑ Crohn's disease
❑ Alzheimer's disease ❑ Multiple sclerosis ❑ Rheumatoid arthritis ❑ Stroke ❑ Heart disease
❑ Other? _____

Grandparents (either one):
Diagnosed Conditions:
❑ High blood pressure ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Cancer ❑ Crohn's disease
❑ Alzheimer's disease ❑ Multiple sclerosis ❑ Rheumatoid arthritis ❑ Stroke ❑ Heart disease
❑ Other? _____

Registry Card Holder Medical History

Are you currently taking any medications on a regular chronic basis? Check those that apply.
Prescription medication? ❑ no ❑ yes OTC medications? ❑ no ❑ yes
Herbal medications? ❑ no ❑ yes Vitamins & Minerals? ❑ no ❑ yes
Please list all medications on the next page: **PDI Medical Medication Flow Sheet**

Any allergies to medications? ❑ no ❑ yes (if yes complete below)
Name of medication /Type of reaction_____
Allergies to any food products? ? ❑ no ❑ yes Type? _____

PDI Medical Medication Flow Sheet

Patient Name		Allergies	
DATE	**MEDICATION**	**DIAGNOSIS**	
Start / Stop	(Dosage/Direction)	(Filled out by consultant)	
		Page ___ of ___	

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Medical Symptoms / Diagnosis
Reason(s) for Evaluation

DIAGNOSIS made by Health Care Provider: (make an X in front of disease (s))

☐	AIDS / HIV	☐	Arthritis of:
☐	ADHD (attention deficit hyperactivity disorder)	☐	Cancer of:
☐	Asthma	☐	Bipolar
☐	COPD	☐	Schizophrenia
☐	Disabled permanently:	☐	Depression
☐	Diabetes w/ extremity pain or nausea?	☐	Migraine Headaches
☐	Glaucoma	☐	Stomach Ulcers
☐	Heart disease	☐	Epilepsy / Seizures
☐	High Blood Pressure	☐	Amyotrophic Lateral Sclerosis (ALS)
☐	Stroke	☐	Hepatitis: B or C
☐	Kidney disease	☐	Multiple Sclerosis / CP
☐	Muscle or Movement Disease	☐	Parkinson's Disease
☐	Other:		Other:

SYMPTOMS you have experienced: (make an X in front of symptoms)

☐	Anxiety / Stress	☐	Depressed feelings
☐	Pain, Joints, where:	☐	Pain, Neck or Back
☐	Headaches	☐	Muscle spasms, where:
☐	Dizziness / Vision problems	☐	Numbness or tingling in limbs
☐	Acid Reflux / Heartburn / Stomach Pain	☐	Insomnia / Sleeping disorder
☐	Loss of appetite / Weight to gain	☐	Nausea / Vomiting
☐	Constipation (especially with medications)	☐	Chronic Cough
☐	Dizziness / Vision problems	☐	Urinary problems
☐	Skin rashes		Other:

For the most significant problem listed above :

Main Problem?	
What caused your problem?	
How long have you had these symptoms?	
Frequency of symptoms?	
Intensity of symptoms? Rate 1-10	
All treatments for this problem? (Physical therapy, medication, other)	
More details	

Patient Statement
Primary Diagnosis and Medical Records

In order to properly counsel on use of medical marijuana, PDI Medical may request, *with your consent only,* copies of your medical records, and prescriptions from your treating physicians.

Consent signature_____

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Prior Cannabis Information

(Fill out if applicable.)

Have you ever used marijuana in a recreational form? ❑ no ❑ yes
Have you ever used medical marijuana? ❑ no ❑ yes

Any information shared is confidential and will not be shared without your consent

Indicate what forms of administration used:
❑ Inhaled (combusted) ❑ Inhaled (vaporized) ❑ Edible ❑ Other _____

Physician Information

Name: _____Phone: _____Fax_____

Address, City, State, Zip: _____

Other Doctors? Name_____Phone _____

Address, City, State, Zip: _____

Emergency Contact

Name of a local friend/ or family member	
Contact #	( )
Relationship to patient	

Patient Research Study
Medical Marijuana

PDI Medical would like input regarding your patient experience

May we contact you for more information? ❑ no ❑ yes

Best Day to contact ❑Monday ❑Tuesday ❑ Wednesday ❑Thursday ❑Friday ❑Saturday
Best time: ❑Morning (8am-11am) ❑Afternoon (11am-3pm) ❑Early Evening (3pm-6pm)

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Disclosures and Conditions
Illinois Laws and Regulations

- I will not divert or provide medical cannabis to unauthorized individuals.
  Patient Initials: _____
- I understand that it must be an Illinois State resident to obtain an approval or recommendation for the use of cannabis (i.e., medical marijuana) under Illinois' Compassionate Use of Medical Marijuana Cannabis Pilot Program Act (410 ILCS 130/)
  Patient Initials: _____
- **I affirm that I have a qualified medical condition which may adversely affect my quality of life**.
  Patient Initials: _____
- I have found or I am interested in determining whether cannabis (i.e., medical marijuana) provides relief and improvement of my condition(s) or symptom(s) of my condition(s).
  Patient Initials: _____
- I have discussed and have been informed by a healthcare provider of the potential benefits and risks of using cannabis.
  Patient Initials: _____
- I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.
  Patient Initials: _____
- I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations (FDA) concerning the safety and effectiveness of the medical use of marijuana as a drug.
  I understand that marijuana is still considered a Schedule I drug under federal regulations.
  Patient Initials: _____
- Illinois' Compassionate Use of Medical Marijuana Cannabis Pilot Program Act (410 ILCS 130/) provides for the possession of cannabis (medical marijuana) for personal medical use regarding conditions under the act.
  Patient Initials: _____

Disclosures and Conditions
Proper use and follow up

I have been notified by this office and agree the use of cannabis may ADVERSELY affect my health. If this occurs I will stop using cannabis and will schedule an appointment to be further evaluated by a physician to determine another form of treatment for relief of my health problems. I assume all risks for usage.

Patient Initials: _____

I agree to obtain medical FOLLOW- UP at my personal medical doctor's office and to return to PDI Medical for FOLLOW-UP, as recommended by the physician. I understand that interaction with healthcare providers is in the best interest for my continuity of care.

THIS IS VERY IMPORTANT –**Patient Initials**_____

I understand that SIDE EFFECTS associated with medical marijuana may include: dry mouth, nausea, headache, tremor, nystagmus, rapid heart rate, reduced muscle strength, decreased brain blood flow, decreased coordination, lung irritation, increased weight gain, altered body temperature, anxiety, paranoia, confusion, aggressiveness, hallucinations, suicidal thoughts, sedation, altered libido, altered perceptions, addictive behavior, reduced testicular size and testosterone, menstrual abnormalities, infertility, abnormal ova, fetal exposure in pregnancy. **Patient Initials:** _____

I agree NOT TO DRIVE a car or operate dangerous or heavy machinery while using marijuana.

Patient Initials: _____

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Disclosures and Conditions
Liability

- Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician, PDI Medical's principals, agents and employees, free and **harmless of any liability** resulting from the use of cannabis-based medicine.
- PDI Medical's staff and representatives are addressing specific aspects of my medical care, unless otherwise stated are in no way establishing themselves as primary care providers.
- I understand that it is **my responsibility** to see a physician to assess the possible continuance of cannabis use beyond the term of approval.
- I understand the potential risks associated with an elevated daily consumption of marijuana including risks with respect to the effect on my cardiovascular and pulmonary system and psychomotor performance, risks associated with the long term use of marijuana as well as potential drug dependency.
- I understand 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 contaminants.
- I understand that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana **may involve risks** that have not been identified.
- I am advised that the cannabis (i.e., Medical Marijuana) smoke may contain chemicals known as tars, which may be harmful to my health.

I certify that I have carefully read all the DISCLOSURES and CONDITIONS above with full understanding and agreement.
I certify that all information I have provided in this 'patient intake form' is true and correct.

_____ _____
Signature Date

PDI Medical LLC

Thanks you for all your input
Never hesitate to ask questions
We look forward to providing you safe access to an alternative treatment

Please Print This Document and Bring To PDI Dispensary for your Appointment