DR. CANNABUS

Phone: 800.827.9927
@drcannabusofficial
info@drcannabus.com
www.drcannabus.com

Intake Questionnaire

1. Do you have a valid Florida driver's license or State ID?

☐ Yes

Florida Driver's License/ID Number

_____

☐ No

What state do you currently hold an active ID?

_____

2. How did you hear about us?

_____

3. Please Enter Your Information Below

First Name: _____

Last Name: _____

Primary Phone Number: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____

Height: _____ Weight: _____ Gender: ☐ Male ☐ Female ☐ Prefer not to Answer

Street Address: _____ City: _____ Zip: _____

State: _____ County: _____

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4. General

- ☐ Allergies
- ☐ Fainting
- ☐ Weight Loss/Gain
- ☐ Depression/Anxiety
- ☐ Headaches
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Other (Please Define Below):

---

5. Muscle/Joint/Bone

- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Stiffness/Tightness
- ☐ Mid-Back Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Soreness/Aches
- ☐ Other (Please Define Below):

---

6. Skin

- ☐ Bruise Easily
- ☐ Hives/Rash
- ☐ Dry/Oily Skin
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other (Please Define Below):

---

7. Cardiovascular

- ☐ Anemia
- ☐ Heart Disease
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Edema
- ☐ Arteriosclerosis
- ☐ High/Low Blood Pressure
- ☐ Rapid/Irregular Pulse
- ☐ Swelling of Ankles
- ☐ Cold Feet
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Varicose Veins
- ☐ Other (Please Define Below):

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8. Women

- ☐ Menopause
- ☐ Currently Breastfeeding
- ☐ Pregnant
- ☐ Plan on Becoming Pregnant
- ☐ Other (Please Define Below):

9. Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Difficulty Breathing
- ☐ Chest Pain
- ☐ Emphysema
- ☐ Other (Please Define Below):

10. Genitourinary

- ☐ Bladder Infection
- ☐ Incontinence
- ☐ Kidney Disorder
- ☐ Other (Please Define Below):

11. Nervous System

- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Numbness/Tingling
- ☐ Other (Please Define Below):

12. Systematic Disorders

- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Post Polio Syndrome
- ☐ Other (Please Define Below):

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13. What is your qualifying condition for medical marijuana?

14. How long have you had this condition?

15. Have you seen a physician or other health practitioner about this? If yes, when? What was the diagnosis?

16. Do you have any known medication allergies?

17. Accidents, injuries, or Surgeries? (Please list Date of procedure)

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18. Please indicate if any of the following apply to you:

- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke or Aneurysm
- ☐ Heart Condition
- ☐ Varicose Veins
- ☐ Bruise Easily
- ☐ Pregnancy
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Hypoglycemia
- ☐ Muscle Strain/Pain
- ☐ Ligament Pain
- ☐ None of the Above
- ☐ Headaches/Migraines
- ☐ Dizziness/Fainting
- ☐ Nausea
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy/Other Seizures
- ☐ Concussion
- ☐ Asthma
- ☐ Respiratory Condition
- ☐ Digestive Condition
- ☐ Skin Condition
- ☐ Depression
- ☐ Anxiety
- ☐ Joint Dislocation
- ☐ Bone Fracture
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Swollen Joints
- ☐ Aching Joints
- ☐ Rods/Pins/Plates/Shunts
- ☐ Transplant
- ☐ Corrective Lenses/Contacts
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV
- ☐ Allergies

19. Habits and Lifestyle

Do you smoke? ☐ Yes ☐ No Do you Drink Alcohol? ☐ Yes ☐ No How Frequently? _____

20. Please list all prescription Medications and Specify the date you started using them.

	Medication	Date First Used	Dosage
1			
2			
3			

21. Is there anything else about your health history that you think would be useful for your physician to certify you for medical marijuana?

_____

_____

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22. Have you used or are you currently using marijuana? If so, when?

_____

23. What routes of marijuana do you want to use?

- ☐ Vape/Inhalation
- ☐ Topical Cream
- ☐ Sublingual/Tincture
- ☐ Oral Pill
- ☐ Edible
- ☐ Flower/Bud