OWP NEW PATIENT HEALTH HISTORY

Name: ____ Date of Birth: ________________

PLEASE STATE YOUR CURRENT HEALTH CONCERN(S):

____

____

____

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

What are the symptoms: ____

____

What makes it better, and what makes it worse? ______________________________________

____

Does it interfere with your ability to function or sleep? Please describe. ______________________

____

When and how did this condition start? ____

____

What types of examinations have you had (doctors seen, tests performed, etc.)?

____

____

What treatments have you tried and how well have they worked? ______________________________

____

PLEASE LIST YOUR CURRENT MEDICINES, SUPPLEMENTS, HERBS (with dosage/amount):

____

____

PLEASE LIST ANY ALLERGIES (medications, food or environmental & your reactions):

____

____

DO YOU CURRENTLY HAVE A PRIMARY CARE PROVIDER? YES NO (Please circle)

Name, City, and Practice____

What other medical providers are involved in your care, if any?

____

____

CANNABIS HISTORY:

Are you currently using cannabis? YES NO (Please circle. If no, please skip to next section). How?
Please circle: Pipe Joint Vaporizer Tincture Edible Juicing Topical Capsule Concentrate Other:
____

How much cannabis do you use? (ex., 2 puffs twice daily,1⁄4 ounce per week, 40 mg daily, etc.)

____

Which strains work well, which don't?
____

How does cannabis help you? ____

Have you had any negative effects from cannabis? YES NO (Please circle. If yes, please describe:

____

____

MEDICAL HISTORY:

Please list any other major health problems, hospitalizations, and surgeries that you have had and when:

____

____

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Please list any traumas you have experienced (accidents, falls, head injuries, abuse as a child, loss of loved ones, fires, abusive relationships, sexual assault, military combat, etc.):

____

____

Have you been diagnosed with any of the following illnesses? (Please circle)

Fibromyalgia   Chronic Fatigue Syndrome   POTS   Rheumatoid arthritis   Lupus   Multiple Sclerosis   ALS, Bell's Palsy   Costochondritis   Transverse Myelitis   Idiopathic Neuropathy   Dementia.

Do you have any of the following symptoms? (Please circle)

Joint Pain or Swelling   Severe Fatigue that is worse after activity   Numbness   Tingling   Radiating Pain
Muscle or Tendon Aches   Pain in Ribs, Chest, or between Shoulder Blades   Swollen Glands
Unexplained Fevers, Sweats, or Chills   Unexplained Lapses in Memory, Attention, Concentration, or the Ability to Process Numbers   Unprovoked Mood Swings   Feel Like You Are Aging Prematurely
Do the above problems seem to come and go without a clear cause?   YES   NO   (Please circle)   Have you noticed a pattern in the occurrence of these symptoms (e.g. monthly)?   YES   NO   (Please circle)   Do the symptoms move around from one area of the body to another or switch sides?   YES   NO   (Please circle)

Other Symptoms (Please circle any that you have experienced in the last 2 weeks):

GENERAL: Persistent Fatigue   Weakness   Fever/Chills   Dizzy   Fainting   Weight Loss/Gain

HEAD: Headaches   Eye Pain   Trouble Seeing   Trouble Hearing   Ringing in Ears   Ear Pain   Stuffed Nose   Tooth Pain   Sore Throat   Swollen Glands

BREATHING: Cough   Excess Phlegm   Bloody Phlegm   Shortness of Breath   Wheezing

Other Symptoms (Please circle any that you have experienced in the last 2 weeks) - COMTINUED

HEART & CIRCULATION: Chest Pain Swollen Ankles Trouble Breathing When Laying Down Trouble

Walking Up Stairs Legs Cramp After Walking Heart Races or Skips Beats.

DIGESTIVE: Heartburn or Reflux Belly Pain Poor Appetite Nausea Vomiting Constipation Diarrhea Blood in Vomit or Stools Black or Tarry Stools Excess Belching or Passing Gas Rectal pain

URINARY: Pain or Burning with Urination Frequent Urination Blood in Urine Decreased Urine Stream Leaking Urine

MUSCULOSKELETAL: Back Pain Painful Muscles Painful Joints Swollen Joints Morning Stiffness Muscle Cramps

NEUROLOGICAL: Radiating Pain Tingling Numbness Weakness Blackouts Tremors Seizures Trouble with Balance or Coordination Memory Changes

MENTAL/BEHAVIORAL HEALTH: Persistent Sadness Worry Anxiety Guilt Fear Paranoia Over-Energized Trouble Paying Attention Panic Attacks Irritability Flashbacks Under-Eating Over-Eating Thinking About Harming Myself or Another Person

OTHER: Can't Tolerate Heat/Cold Excessive Sweating Nipple Leaking Change in Appetite/Thirst Rash Skin Changes Changed Libido Trouble or Pain with Sex.

WOMEN: Irregular bleeding Problems with Periods Lump(s) in Breast(s) Vaginal Dryness Hot Flashes

FOR MEN: Erection problems; Lumps or pain in testicles

FAMILY MEDICAL HISTORY:

Mother: ____

Father: ____

Siblings: ____

Grandparents: ____

Other: ____

LIFESTYLE AND SOCIAL LIFE:

How many cups or glasses do you drink per day?: Water: _____ Caffeinated beverages: _____ What else do you drink and how much? ____ How many alcoholic beverages do you drink per week and what type (ex., wine, beer, liquor)? ______________________ ____ Tobacco (type, how much, and how long of use)? _________ ____ How much exercise do you get per week and what type? ____ ____

How many hours of sleep do you get each night? _______ (hours) Do you feel rested the next morning? (Please circle) Yes No Have you had any recent major life changes? YES NO (Please circle and explain, if yes) ____ ____

What do you do for fun and relaxation? ____ ____

With Whom do you live (ex., alone, spouse, parent, friend? ____ Do you feel safe at home? YES NO (please circle) Are you? Employed ____ Unemployed ____ Disabled ____ Other ____ What do you do for work? ____ ____

WHAT ARE YOUR HEALTH AND HEALING GOALS? WHAT ARE YOUR GOALS FOR THIS VISIT?

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