Medical Information Form

Age: Sex: Male Female Other Are you pregnant? YES NO UNSURE N/A Are you breast-feeding? YES NO UNSURE N/A Allergies? YES NO UNSURE N/A Allergies? YES NO TYPE HOW OFTEN? Allordor use: YES NO TYPE HOW OFTEN? Alcohol use: YES NO HOW OFTEN? Recreational drug use: YES NO If yes, please list: Please list and prescription medication you are <u>currently</u> taking: What conditions do you want to treat with medical cannabis? What conditions do you want to treat with medical cannabis? What conditions do you want to treat with medical cannabis? What was these conditions impacted your daily life? Have they progressed? Why do you want to use medical cannabis to treat these conditions? Telemedicine Consent Form 1. The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in the diagnosis and treatment of: 2 3 2. Telemedicine involves the use of audio, video, or other electronic communications to: interact with you, consult with your healthcare provider (our physician), and or review your medical information for the purpose of your consultation. Initial here: 3 2. Any of the patient identifiable images or information from the telemedicine consultation shall not occur without your consent. Initial here: 3. Any of the patient identifiable images or information from the telemedicine consultation. Initial here: 3. Any of the patient identifiable images or information provided above. I have had the opportunity to as questions and all have been answered. I have agreed to a telemedicine consultation.	Name: First MI Last
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