Medical Information Form

Name: First _____ MI _____ Last _____

Age: _____

Sex: Male _____ Female _____ Other _____

Are you pregnant? YES ____ NO ____ UNSURE ____ N/A ____

Are you breast-feeding? YES____ NO____ N/A____

Allergies? YES____ NO____

List Allergies:_____

Tobacco use: YES___ NO___ TYPE_____HOW OFTEN?_____

Alcohol use: YES___ NO___ HOW OFTEN?_____

Recreational drug use: YES____ NO____

Major surgeries? YES____ NO____ If yes, please list:_____

Please list and prescription medication you are currently taking:

_____

What conditions do you want to treat with medical cannabis?

_____

How long have you had these conditions?

_____

List any previous treatments for these conditions, and if they helped:

_____

How have 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:

   1._____ 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. Any of the patient identifiable images or information from the telemedicine consultation shall not occur without your consent. **Initial here:_____**
4. All existing confidentiality protections apply to information used or disclosed during your telemedicine consultation. **Initial here:_____**

A Better Bloom Health & Wellness has disclosed with me the information provided above. I have had the opportunity to as questions and all have been answered. I have agreed to a telemedicine consultation.

Patient Signature_____ **Date**_____