

New Patient Application



Date:

Name:
Address:
State/Province:
Zip/Postal Code:
D.O.B.

Prestige Medical Center
7901 Santa Monica Blvd. Suite 208
West Hollywood, CA 90046

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Home Phone:
Cell Phone:
E-Mail:

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How Did You Hear About Us?

** If you were referred by a friend or a family member, enter his/hers name.*

Are you currently On Probation? Or Parole?

Past Medical History

If you are currently being treated for the condition you are being evaluated for, please complete the following:

Name of Physician
Address of Physician
City/State/Zip
Phone and/or Fax
Date/Year of last visit

Please list any medical condition that

- 1) A physician has evaluated you for
- 2) You were admitted to a hospital for
- 3) Are currently being treated for

Example: Arthritis, High Blood Pressure, Glaucoma, Migraine Headaches, Diabetes, Anxiety, Asthma, Hepatitis C

(1)
(2)
(3)

Do you have a history of: Heart Disease? Lung Disease?

Initials: _____

Surgical History

Date	Hospital Name	Doctors Name	Reason

Current Medications

Please list medications (if any) that you might have allergies to

Please list all medications, including Over The Counter medications that you are taking on a daily or occasional basis.

Family Medical History

Please provide (if any) medical conditions exist within your immediate family members

Mother

Father

Brothers

Sisters

Social History

Please explain how often and how much (if) you consume any of the following.

Example: 5-6 Drinks a Week

Alcohol:

Marijuana

Cigarettes

Other

** Under Other, please list any of the recreational drugs you might use such as Heroin, Cocaine, Ecstasy, Mushrooms or others*

Initials: _____

Conditions / Complaints

Please describe the medical condition or complaint that you are seeking a recommendation for medical marijuana:

** Please include when you first noticed the symptoms and when you received the diagnosis*

Do you currently use cannabis to treat your current medical condition? Yes No

If YES, for how long?

Did you ever have any allergic reactions to cannabis? Yes No

Please explain how it provides relief for your symptoms (example: less pain)

What method do you currently use to consume the cannabis? Ingest Vaporize Smoke

Please describe all treatments that you have received to date for your current medical problems such as the medications prescribed, surgeries, physical therapy, acupuncture, homeopathy, chiropractic care or other:

Initials: _____

Additional Information

Please provide any other information you believe is relevant to your evaluation

Physicians Comments: (leave blank)

Patient Name: _____

Date: _____

Patient Signature: _____

Physicians Name: _____

Date: _____

Physicians Signature: _____