Green Health Consultants

NEW PATIENT INFORMATION & HEALTH HISTORY

Patient's name_____ M☐ F☐
Birth Date_____
Patient's address
_____

_____
Email:_____

Telephones:
home_____ work_____ cell _____

single☐ married☐ other☐ children _____

Occupation
_____
Patient's employer or school
_____

Patient's Primary Care Physician (and/or Referring Physician) _____

Emergency Contact Info:
Name: _____ Relationship: _____
Phone:_____

Referred by: _____

Green Health Consultants
3184 Old Tunnel Rd. Ste E Lafayette, CA 94549
http://www.greenhealthconsultants.com

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NEW PATIENT HEALTH HISTORY

Name: _____Date of Birth:_____

Place Check next to any of the following symptoms that you have been experiencing:
Weakness: ☐ Cachexia: ☐ Wasting syndrome: ☐ Intractable pain: ☐ Nausea: ☐
Impairing strength or ability: ☐

Place Check next to any of the following medical conditions you have been diagnosed with:
Cancer: ☐ AIDS: ☐ Parkinson's Disease: ☐ Glaucoma: ☐ ALS: ☐ Multiple Sclerosis: ☐

PTSD: ☐ Hepatitis C ☐ HIV Positive: ☐ Crohn's Disease: ☐ Other(specify):_____

Place Check next to any of the following major life activities/categories that are affected by your condition and/or symptoms.
Mental: ☐ Emotional: ☐ Social: ☐ Employment: ☐ Recreation: ☐ Physical: ☐

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING: What are your current symptoms (be as descriptive as possible)

_____

_____

_____

What makes it better, what makes it worse?

_____

_____

Do the symptoms that you are currently experiencing improve with marijuana use? If so, please explain.

_____

_____

How did this condition start?

_____

_____

_____

What type of workup have you had (doctors seen, tests performed, etc.)?

_____

_____

_____

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What treatments have you tried? How well have they worked?

_____

_____

_____

Are you in Pain? _____
Where is your Pain?

_____

CURRENT MEDICAL CARE: Primary Care Provider (name, practice name or location):

_____

Approximate date of last physical examination: _____ by whom?

_____
Would you like us to send a copy of your office visit note to your PCP or other providers? (Circle) YES NO

I am or have been treated by a: Talk therapist _____ Social worker _____ Psychiatrist _____ Pain specialist_____
Heart specialist_____ Nerve specialist_____

Other health care professional(s) you are seeing and for what conditions:

_____

_____

CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage please):

_____

_____

ALLERGIES? (include reactions to medicines):

_____

LIFESTYLE:
I have finished: Middle School____ High School ____ College ____ Post-Graduate Degree ____
I am: Employed____ Unemployed____ Disabled____ Other_____
How many hours of sleep do you get a night? _____ Trouble sleeping or sleeping too much?

_____
How many cups or glasses do you drink per day: water:_____ milk:____ caffeinated beverages:_____
How many alcoholic beverages do you drink per week: _____Tobacco: _____
Drugs_____
What substances have you used in the past:
Cocaine_____ Heroin_____ RX drug abuse_____ Mushrooms_____ Acid_____ Ecstasy_____
ETOH_____ Other_____
How much exercise per week (what kind?)

_____
What do you do for fun?

_____
Any recent major life changes?

_____

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FAMILY MEDICAL HISTORY: (please list any conditions that run in the family, indicate if alive or deceased)
Mother_____
Father
_____
Siblings_____

CANNABIS HISTORY
Are you currently using marijuana to alleviate any symptoms that you are experiencing? Yes☐ No☐
If so, which
symptoms:_____
If you were not using cannabis to treat your symptoms, how would you
feel?_____
_____
At What Age did you first use Cannabis?_____
Dosage (i.e. 2-3 puffs three times daily, or . ounce per week)
_____
_____
If you smoke/vaporize, how many inhalations do you use in one sitting?_____
Delivery System (i.e. pipe, joint, vaporizer, tincture, etc.)
_____
High/Low Quality? Strain?
_____
Have you had any adverse affects from cannabis?
_____
Have you ever had a reaction from cannabis? (circle) anxiety, depression, paranoia,
other_____

"REVIEW OF SYMPTOMS" Check off any of the following symptoms you have/had experienced in the PAST 2 WEEKS: GENERAL:

HEAD:

☐ weight change ☐ headaches ☐ eye pain ☐ runny nose ☐ painful teeth
☐ tired/weak ☐ glaucoma ☐ hearing loss ☐ stuffy nose ☐ bleeding gums
☐ dizzy/fainting ☐ cataracts ☐ noise in ears ☐ nosebleeds ☐ dentures
☐ fever/chills ☐ blurry vision ☐ earaches ☐ sore throats ☐ goiter
☐ hearing aids ☐ voice change ☐ swollen glands

RESPIRATORY:

☐ cough ☐ cough with phlegm ☐ cough with blood ☐ wheezing ☐ short of breath

HEART & CIRCLATION:

☐ high blood pressure ☐ heart races or skips beats ☐ chest pain
☐ short of breath after climbing steps ☐ short of breath while laying in bed ☐ legs swell
☐ legs hurt or cramp when walking ☐ varicose veins

DIGESTIVE:

☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ nausea ☐ vomiting (with blood?)
☐ diarrhea ☐ constipation ☐ excess belching or passing gas ☐ change in stool (with blood?)

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☐ hemorrhoids ☐ rectal pain ☐ jaundice ☐ gallbladder pain ☐ abdominal pain & swelling

URINARY:

☐ burning with urination ☐ frequent urination ☐ change in urine stream ☐ (with blood?)

☐ frequent urinary infection ☐ lose urine if you cough or sneeze ☐ kidney stones

MUSCULOSKELETAL:

☐ pain in muscles or joints ☐ morning stiffness ☐ backache ☐ sciatica ☐ low back pain

☐ arthritis ☐ gout ☐ short leg ☐ wear a shoe lift ☐ scoliosis ☐ muscle spasms

NEUROLOGICAL:

☐ blackouts ☐ seizures ☐ numbness or loss of sensation ☐ tingling or "pins and needles"

☐ remors or other involuntary movements ☐ weakness in arms or legs ☐ trouble walking

☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst or hunger

☐ excessive urination ☐ nervousness ☐ tension ☐ difficulty with memory ☐ skin changes / rash

MENTAL HEALTH:

☐ racing thoughts ☐ difficulty concentrating ☐ bipolar disorder ☐ seeing things

☐ hearing voices in your head ☐ un-realistic fears ☐ guilty feeling

☐ poor coordination ☐ anger problems ☐ thoughts of killing myself or others ☐ risky driving

☐ casual sex ☐ moodiness ☐ feeling empty inside ☐ "hyper" ☐ unstable relationships

☐ no friends ☐ Feeling alone ☐ Addictions ☐ Anxiety ☐ Panic ☐ Obsessive thoughts

☐ Cutting myself ☐ eating disorder ☐ people trying to harm or harass me ☐ depression

☐ nervousness ☐ not needing sleep ☐ easily distracted ☐ feeling of being followed

☐ people are conspiring or out to get you

MALE PATIENTS:

☐ urinary stream slower, smaller ,split ☐ lumps or pain in testicles ☐ erection problems ☐ sores

FEMALE PATIENTS:

☐ breast tenderness or pain ☐ breast lumps ☐ nipple discharge ☐ hot flashes

☐ change in menstrual cycle, bleeding or pain ☐ vaginal sores or discharge ☐ painful intercourse

Age your periods began: _____ Number of days period lasts: _____ Date of last period _____

Number of pregnancies _____ Number of deliveries _____ Age at menopause: _____

Birth control method: _____