

**HEALTH HISTORY QUESTIONNAIRE**

SCC © 7.1

<http://www.ccrmg.org/>

**Identifying Data:**

Initial visit date: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ and/or CDL#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Best time to contact: \_\_\_\_\_ anytime / morning / afternoon / evening / OK @ work

Race: African / Asian / Hispanic / Indo-European / Native American / Pacific Is. / Other \_\_\_\_\_

Occupation(s): \_\_\_\_\_

Current employment: Full Time / Part Time / Unemployed / Retired / Disabled

Emergency contact: (Name, Relationship, Phone) \_\_\_\_\_

**Demographic Information:**

Birth order: Born 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> 6<sup>th</sup> 7<sup>th</sup> \_\_\_\_ Out of 1 2 3 4 5 6 7 \_\_\_\_

Birthplace: \_\_\_\_\_

Years of education: <10 / 11 / 12 / 13 / 14 / 15 / 16 / 17 / > \_\_\_\_ Degree(s) obtained: \_\_\_\_\_

Major or Area of Specialty: \_\_\_\_\_

Occupation(s) / Other Training, Certifications: \_\_\_\_\_

Military: Yes / No Branch of Service: Army / Air Force / Marines / Navy / Coast Guard

Service in Viet Nam: Yes / No Gulf War: Yes / No Other: \_\_\_\_\_ Highest Rank: \_\_\_\_\_

Length of Service: From \_\_\_\_ To \_\_\_\_ Discharge: Honorable / Dishonorable / General / Medical / Other

Citations: \_\_\_\_\_

Marital status: Circle past and current status with # of years each

Single \_\_\_\_ Married \_\_\_\_ Partner \_\_\_\_ Widowed \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_

Spouse / partner's name: \_\_\_\_\_ Spouse / partner's occupation: \_\_\_\_\_

Living Situation: alone / with spouse / partner / with parent(s) / with children / with friend(s)

Domicile: house / mobile home / apartment / institution / homeless / other \_\_\_\_\_

Household members: first name, age and relationship \_\_\_\_\_

**General Information:**

Do you have medical insurance? Yes / No

If yes, Identify: MediCal, Medicare, HMO, PPO, Kaiser, None, etc.: \_\_\_\_\_

Primary care physician or clinic, Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Specialist / Consultant, Name and Location: \_\_\_\_\_

Specialist / Consultant, Name and Location: \_\_\_\_\_

Specialist / Consultant, Name and Location: \_\_\_\_\_

Do you receive a pension, insurance payment or compensation for illness or injury? Yes / No

Are you a registered voter? Yes / No

Have you named an agent to make health care decisions for you: Yes / No

Have you put it in writing? Yes / No

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

ICD-9 (per MD): \_\_\_\_\_

**Medical History**

**Chief Complaint:**

What is the main problem for which you seek evaluation and treatment today (or the main reason you currently use cannabis) i.e. nausea, anorexia, spasms, pain, etc.? \_\_\_\_\_

**When did this problem start?** < 1 month / < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years

**When did you last see your doctor or a specialist about this complaint?**

< 1 month / < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years

**Trauma or Injury Questions:**

Date of Injury / Illness \_\_\_\_\_

Have you been injured in traffic accidents? Yes / No \_\_\_\_\_ Date(s): \_\_\_\_\_

Have you been injured in other accidents? Yes / No \_\_\_\_\_ Date(s): \_\_\_\_\_

Have you had any fractures or dislocations? Yes / No \_\_\_\_\_ Date(s): \_\_\_\_\_

Have you been injured in an assault or fight? Yes / No \_\_\_\_\_ Date(s): \_\_\_\_\_

Have you been injured after use of alcohol? Yes / No \_\_\_\_\_ Date(s): \_\_\_\_\_

Have you had a head injury? Yes / No \_\_\_\_\_ Date(s): \_\_\_\_\_

**Check treatment modalities that you have tried in treating your problem:**  medications,  surgery,  therapeutic injections,  physical therapy,  osteopathic care,  chiropractic care,  acupuncture,  counseling, other: \_\_\_\_\_

**Current Prescription Medications:** List names, dosage, frequency of use, and how long taken

1. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

2. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

3. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

4. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

5. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

6. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

**Previous Prescription Medications (relevant):** List names, how long taken, and why stopped

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Over-the-Counter and Herbal Medications:** List products that you use or have used in the past for the condition for which cannabis is used (intended), i.e. ibuprofen, aspirin, glucosamine, milk thistle,

**Medication Allergies:** \_\_\_\_\_

Medication Intolerance: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

**Other drug use:**

Tobacco: Yes / No Cigarettes /day \_\_\_\_\_ Years of smoking \_\_\_\_\_ Quit date \_\_\_\_\_

Alcohol: Yes / No Drinks /day or week \_\_\_\_\_ Years of drinking \_\_\_\_\_ Quit date \_\_\_\_\_

Caffeine: Yes / No Cups / day [Coffee \_\_\_\_ Tea \_\_\_\_ Soda \_\_\_\_] Years of drinking \_\_\_\_\_ Quit date \_\_\_\_\_

Opiates / Heroin: \_\_\_\_\_ times per month Years of use \_\_\_\_\_ Quit date \_\_\_\_\_

Cocaine: \_\_\_\_\_ times per month Years of use \_\_\_\_\_ Quit date \_\_\_\_\_

Amphetamines / Ecstasy \_\_\_\_\_ times per month Years of use \_\_\_\_\_ Quit date \_\_\_\_\_

LSD / Psilocybin / Peyote: \_\_\_\_\_ times per month Years of use \_\_\_\_\_ Quit date \_\_\_\_\_

**Family Medical History** ( ✓ check box)

Are you adopted? Yes / No

	Alive Age	Deceased Age	Heart Disease	Hyper-tension	Stroke	Diabetes	Cancer	Substance Abuse	Mental Disorder	Arthritis	Other
Mother											
Father											
M Gmother											
M Gfather											
P Gmother											
P Gfather											

Ages and health of brothers, sisters and children:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History**

**Medical Conditions:** (✓check box) Do you have problems with:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Herpes zoster / shingles / other
<input type="checkbox"/> Back and neck pain	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Blood Disorders (anemia, Abn. clotting)	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Brain disorders (epilepsy, trauma, etc)	<input type="checkbox"/> Intestinal disorders (ulcers, colitis, IBS)
<input type="checkbox"/> Breast lesions	<input type="checkbox"/> Kidney disease (cystitis, renal failure)
<input type="checkbox"/> Cancer, specify:	<input type="checkbox"/> Liver disease (cirrhosis, hepatitis B or C)
<input type="checkbox"/> Chronic pain, specify:	<input type="checkbox"/> Lungs disease (asthma, emphysema)
<input type="checkbox"/> Circulation (stroke, phlebitis, etc)	<input type="checkbox"/> Mental disorders (depression, anxiety, PTSD)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine headache
<input type="checkbox"/> Dystonia (spasms, tremors, Parkinson's)	<input type="checkbox"/> Multiple sclerosis (neurodegenerative disease)
<input type="checkbox"/> Ear problems (tinnitus, hearing loss)	<input type="checkbox"/> Prostate disease
<input type="checkbox"/> Eating disorder (anorexia, bulimia)	<input type="checkbox"/> Rheumatic disease (Lupus, Sjogrens, Reiters)
<input type="checkbox"/> Endocrine problems (thyroid, hormones)	<input type="checkbox"/> Skin disorders (psoriasis, eczema)
<input type="checkbox"/> Eye problems (glaucoma, cataracts)	<input type="checkbox"/> Sleep disorders (insomnia, sleep apnea)
<input type="checkbox"/> Genital / GYN problems	<input type="checkbox"/> Substance abuse (tobacco, alcohol, other drugs)
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Weight loss / gain

**Females Reproductive History:**

Number of pregnancies \_\_\_\_\_ Number of children \_\_\_\_\_ Children's present ages \_\_\_\_\_

Are you pregnant now? Yes / No Are you planning a pregnancy? Yes / No

Are you currently breastfeeding? Yes / No

**Past Surgical History**

Please list in chronological order surgeries and approximate dates.

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_
4. \_\_\_\_\_ Date: \_\_\_\_\_
5. \_\_\_\_\_ Date: \_\_\_\_\_
6. \_\_\_\_\_ Date: \_\_\_\_\_

## **Cannabis Use Pattern**

At what age did you first use cannabis? \_\_\_\_\_ years old      Was your first use social? Yes / No  
At what age did you discover that cannabis eased your medical symptoms? \_\_\_\_\_ years old  
What were the circumstances? \_\_\_\_\_

---

---

Type of cannabis preferred: Sinsemilla, whole plant, hashish, kief, oil, other \_\_\_\_\_  
Method: Inhaled: vapor, smoke ( joint, pipe, water pipe )  
Ingested: tea, capsules, butter / oil, tincture, baked goods, other \_\_\_\_\_  
Rectal / vaginal suppository  
Topical: tincture, cream / ointment, poultice, parabath, DMSO

How often do you use cannabis:

1 X / month, 2-3 X / week, 1 X / day, 2 X / day, 3 X / day, 4 X / day, >4 X / day

Estimate the average amount of cannabis you use per day? (large joint = 1 gram, 1/8 oz. = 3.5 gm)

< 1 gram, 1 gram, 2 grams, 3 grams, 4 grams, 5 grams, 6 grams, other \_\_\_\_\_

Would you use more if it were 1) easier to obtain? Yes / No 2) cheaper to obtain? Yes / No

How much more? 25% 50% 75% 100% Other: \_\_\_\_\_

Has the amount of cannabis needed to control your symptoms changed over time?

1) much more 2) little more 3) about the same 4) little less 5) much less 6) variable

If changed, to what do you attribute the change: \_\_\_\_\_

---

How effective is cannabis in treating your condition?

1) Much better (very effective) 2) Better (effective) 3) Slightly better (somewhat effective)

How does cannabis compare with your usual prescribed medicines in relieving your symptoms?

1) Prescribed medicines work much better 4) Cannabis works a little better than prescribed medicines

2) Prescribed medicines work a little better 5) Cannabis works much better than prescribed medicines

3) Prescribed medicines work no better 6) Cannabis and prescribed medicines work best together

7) Explain: \_\_\_\_\_

---

Have you ever stopped using cannabis only to find that your symptoms return or worsen? Yes / No

Explain: \_\_\_\_\_

If your symptoms disappear or are substantially reduced would you keep on using cannabis? Yes / No

Have you ever used synthetic THC (Marinol) Yes / No      If yes, compare effect of Marinol to natural cannabis: \_\_\_\_\_

Does use of cannabis modify your use of other drugs? Yes / No Explain: \_\_\_\_\_

Does use of cannabis modify your use of alcohol? Yes / No Explain: \_\_\_\_\_

Do you use, or have you used an antidepressant (SSRI) and cannabis together? Yes / No If yes, describe the effect of each. Antidepressant: \_\_\_\_\_ Cannabis: \_\_\_\_\_

Describe bothersome adverse effects that you have to cannabis: \_\_\_\_\_

Are there other reasons for which you use cannabis? \_\_\_\_\_

---

How has your cannabis use affected your relationship with your family? \_\_\_\_\_

---

**Developmental History**

Childhood Illnesses / Injury: \_\_\_\_\_  
Breastfed: Yes / No / Uncertain  
Dominant Hand: Right / Left / Ambidextrous  
Parenting: 1) Two parent, 2) One parent, 3) Other \_\_\_\_\_  
Your religion \_\_\_\_\_ Your parent's religion \_\_\_\_\_  
Hours of TV / Day: Preschool: \_\_\_\_\_ Grade school: \_\_\_\_\_ Middle school: \_\_\_\_\_ High school: \_\_\_\_\_  
Were you subject to abuse in home life? Yes / No Explain \_\_\_\_\_  
Did you change schools frequently? Yes / No Explain \_\_\_\_\_  
Did you have reading or learning disabilities? Yes / No Explain \_\_\_\_\_  
Did you have behavior problems in school? Yes / No Explain \_\_\_\_\_  
Were you a bully or subject to bullying in school? Yes / No Explain \_\_\_\_\_  
Did you take prescription medication for behavior or mood problems in school? Yes / No \_\_\_\_\_  
Are you familiar with ADD? Yes / No Do you think the diagnosis applies to you? Yes / No  
Did you begin regular alcohol or drug use in school? Yes / No Explain \_\_\_\_\_

**Immunization Record:** (circle)

MMR (Measles, Mumps, Rubella), Polio, DPT (Diphtheria, Pertussis, Tetanus), Pneumonia, Hepatitis A, Hepatitis B, Meningococcus, Hemophilus, Chicken Pox, Flu Shots,  
How many years since your last: Tetanus: \_\_\_\_\_ TB skin test: \_\_\_\_\_

**Social Questions**

Do you suffer from household stress? Yes / No  
Are you a child of an alcoholic family? Yes / No \_\_\_\_\_  
Are you an alcoholic? Yes / No Have you ever blacked out? Yes / No  
Compare your alcohol use now with past use: \_\_\_\_\_  
Do you feel unsafe in your home? Yes / No If yes, explain \_\_\_\_\_  
Do you feel unsafe in your community? Yes / No If yes, explain \_\_\_\_\_

**Medical Legal**

Are you on probation or parole? Yes / No Explain (Case #, County) \_\_\_\_\_  
Do you have a pending cannabis case? Yes / No Explain \_\_\_\_\_  
Are you subject to workplace drug testing? Yes / No Explain \_\_\_\_\_  
Would you like to be contacted for participation in cannabis clinical research studies? Yes / No  
Is there any other information the doctor should be aware of? \_\_\_\_\_

**Review of Systems** (You may complete this section with the physician)

CONST: All neg Fever Sweats Chills Night Sweats Appetite Loss Weakness Malaise Lightheadedness Fainting  
Dizziness Vertigo Insomnia Sleep Apnea Nightmares Weight Loss / Gain Weight Range \_\_\_\_\_ to \_\_\_\_\_  
EYES: All neg Vision Loss Vision Change Blurred Vision Corrective Lens Cataracts Glaucoma Iritis  
ENT: All neg Tinnitus Hearing loss Ear Infections Sinus Infections Nose bleeds Difficulty Swallowing Jaw Pain Hoarse  
CARDIO: All neg Chest Pain Palpitations(Slow Fast Irregular) Pacemaker Fatigue Leg Cramps Edema Shortness of Breath Orthopnea  
RESP: All neg Wheezing Cough Sputum Hemoptysis Pleuritic Pain Shortness of Breath Exertional Dyspnea  
GI: All neg Nausea Vomiting Diarrhea Constipation Abd Pain Reflux/Heartburn Hematemesis Hematochezia  
Melena Rectal Pain Hemorrhoids Jaundice Gas  
GU: All neg Dysuria Frequency Nocturia Urgency Hesitancy Infections Incontinence Libido Change Testicle Pain/Swelling Abn. Prostate  
Regular Menstrual Cycling Irreg Menses Abnormal Bleeding Peri / Post Menopause G \_\_\_\_\_ P \_\_\_\_\_ Ab \_\_\_\_\_ Pap \_\_\_\_\_ Mammo  
MS: All neg Joint Pain: \_\_\_\_\_ Back / Neck Pain \_\_\_\_\_ Bone Pain Muscle Pain Muscle Spasm Loss ROM Sciatica  
SKIN: All neg Moles Subcut Nodules Skin Cancer Rash Psoriasis Eczema Scars Other Lesions Tattoo Photosensitivity  
ENDO: All neg Fatigue Polyuria Polydipsia Hair Change Skin Change Heat / Cold Intolerance  
HEMELYMPH: All neg Easy Bruising Easy Bleeding Swollen Nodes Petechiae Varicose Veins  
IMMUNO: All neg Asthma Seasonal Allergies Hives Itching Angioedema Rhinorrhea Raynaud's  
NEURO: All neg Headache Nerve Pain Seizure Focal Weakness Focal Numbness Paralysis Tremor Spasticity Memory Loss Phantom Pain  
PSYCH: All neg Anxiety Agitation Panic Aggression Suicidal Thoughts / Acts Depression (Reactive / Major) Delusions Hallucinations

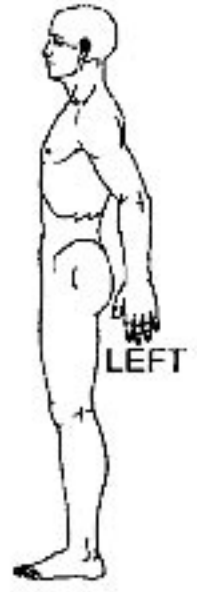
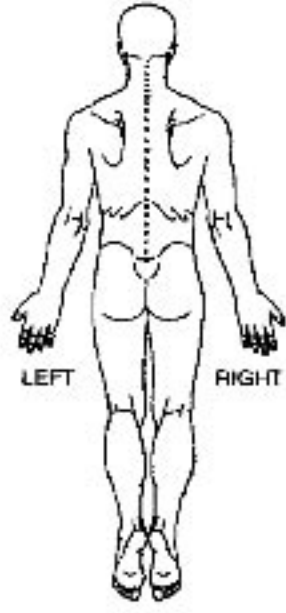
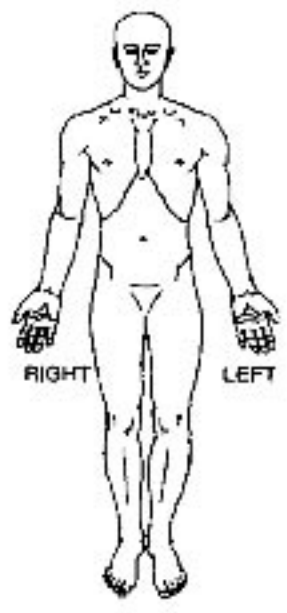
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**Release of Liability**

I understand that I must be a California State resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under California’s Compassionate Use Act of 1996 (Health & Safety Code #11362.5).

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether cannabis (medical marijuana) provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/or contaminants. In requesting an approval or recommendation for the use of this plant as medication I assume full responsibility for any and all risks of this action.

I am advised that the cannabis (medical marijuana) smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that vaporizing cannabis may eliminate exposure to tar. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician.

I am advised that the use of cannabis (medical marijuana) may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I assume full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

California’s Compassionate Use Act of 1996, (Health & Safety Code #11362.5), provides for the possession and cultivation of cannabis (medical marijuana) for the personal medical purposes of the patient with a physician approval or recommendation. It should be made absolutely clear that the physician, staff and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in my obtaining cannabis (medical marijuana).

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medicinal cannabis treatment. There are no claims about the medical efficacy of cannabis. The physician, staff, and representatives are addressing specific aspects of my medical care, and, unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use of cannabis I understand that there is a renewal date specified by the physician. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval. Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees, free of and harmless from any liability resulting from the use of cannabis.

I further understand that by signing below, I am authorizing the release of any part of this record, except for identifying information, for use in data analysis of cannabis treated patients.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Minor patient’s parent or legal guardian

Witness \_\_\_\_\_