HEALTH HISTORY QUESTIONNAIRE

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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 1st 2nd 3rd 4th 5th 6th 7th ___ 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 _____

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? _____
_____

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:

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

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)

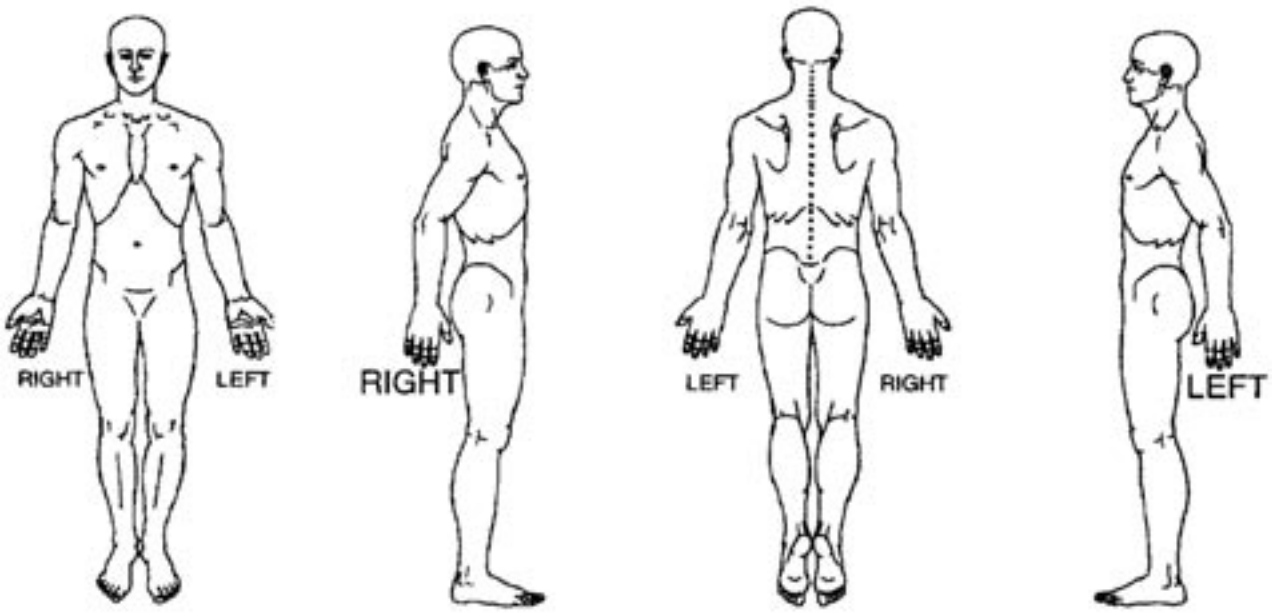
CONST:	All neg	Fever	Sweats	Chills	Night Sweats	Appetite Loss	Weakness	Malaise	Lightheadedness	Fainting		
		Dizziness	Vertigo	Insomnia	Sleep Apnea	Nightmares	Weight Loss / Gain	Weight Range_____ to _____				
EYES:	All neg	Vision Loss	Vision Change		Blurred Vision	Corrective Lens	Cataracts	Glaucoma	Iritis			
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					
HEME/LYMPH:	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			

Brief Pain Inventory
Date: _____/_____/_____
Time: _____

Name: _____
Last **First** **Middle Initial**

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. yes 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE.**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

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8) In the past 24 hours, how much **RELIEF** have pain treatments or medications provided? Please circle the one percentage that most shows how much.

0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, **PAIN HAS INTERFERED** with your:

A. General Activity:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely interferes