



Medical Questionnaire

Today's Date: _____

Name: _____
First M.I. Last Name

Date of Birth: _____ Home #: () _____ Cell #: () _____

Emergency Contact

Name: _____ Relationship: _____ Phone: () _____

Please tell us where you heard about Michigan Holistic Health – check all that apply.

- Physician
 Compassion Club
 Family member/Friend
 Internet / website
 Newspaper
 Print materials
 TV ad
 Radio ad
 Other _____

Primary Care Provider Information

Name: _____ Phone: _____ Specialty: _____

Address: _____
City State Zip

Do you want record of today's visit sent to your Primary Care Provider? Yes No

_____ Please initial to acknowledge that you have brought us all the medical records you can obtain from doctors you have seen for your qualifying condition.

Please list all medications (prescription and/or over the counter) that you are currently taking and their dosage (if known):

Medication Name	Strength/Dose	# of times per day	Start date (month/year)

Do you have any known drug allergies? No ___ Yes ___

If yes, please list: _____

Patient Name: _____ Date of Birth: _____

General: Mark if you have had any of the following in the past 3 months

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Marked Fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Breathing | | |

Social History

- Smoker
 Other tobacco products
 Street Drugs (Other than Marijuana, strictly confidential)
 Alcohol _____ Daily _____ Weekly

Please mark diseases, symptoms or other items corresponding to your current and past health Problems:

Eyes, Ears, Nose, Throat

- Glaucoma
 Cataracts
 Hearing Loss Left Right Both
 Frequent Ear Infections
 Seasonal Allergies
 Sinus Problems
 Difficulty Swallowing
 Eye Pain
 Other _____

Cardiovascular

- High Blood Pressure
 High Cholesterol
 Heart Attack
 Angina
 Cardiac Arrhythmias
 Palpitations
 Pace Maker
 Stroke (Lasting deficits)
 TIA (Symptoms resolved completely)
 Peripheral Vascular Disease
 Other _____

Respiratory

- Asthma
 COPD
 Emphysema
 Chronic Bronchitis
 Pulmonary Embolism
 DVT (Blood Clot)
 Other Lung Problems _____

Integumentary

- Psoriasis
 Photosensitivity
 Skin Cancer
 Other Skin Problems _____

Gastrointestinal

- Chronic Constipation
 Chronic Diarrhea
 GERD
 Ulcers
 Heartburn
 Crohn's
 Colitis
 Cachexia or Wasting Syndrome
 Persistent Nausea
 Frequent Vomiting
 Blood in Stool
 Decreased Appetite
 Diverticulitis
 Other _____

Nervous System

- Migraine or other Headaches
 Nerve pain or Neuropathy
 Insomnia / Sleeping Disorder
 Parkinson's Disease
 Post Herpetic Neuralgia (Shingles pain)
 Head Injury
 Multiple Sclerosis
 Epilepsy/Seizures
 Severe and Chronic Pain
 Other _____

Renal

- Kidney Disease
 Require Dialysis
 Frequent Kidney Stones
 Other _____

Infectious Disease

- HIV/AIDS
 Hepatitis A B C
 Tuberculosis
 Valley Fever
 Other _____

Cancers

- Cancer : Type _____
- Cancer: Type _____
- Family History of Cancer diagnosed before age 50 yrs

***Are you currently or previously Treated with:

- Chemotherapy
 - Started: _____
 - Duration: _____
 - Treatments Per Week: _____
 - End: _____
- Radiation Therapy
 - Body Part: _____
 - Start: _____
 - Duration: _____
 - End: _____

Metabolic/Endocrine

- Diabetes Type I or II (circle one)
- Thyroid Disorder
- Anemia
- Obesity
- Polycystic Ovarian Syndrome (PCOS)
- Metabolic Syndrome
- Other: _____

Musculoskeletal

- Severe and Persistent Muscle Spasms
- Osteoarthritis
- Osteoporosis
- Broken Bone: Where: _____
- Degenerative Disk Disease
- Rheumatoid Arthritis
- Other Arthritis
- Fibromyalgia
- Joint Pain
- Muscle Pain
- Bone Pain
- Amyotrophic Lateral Sclerosis
- Other _____

Surgeries

- Tonsillectomy
- Appendectomy
- Back Surgery
- Other bone/joint surgery
- Procedure to decrease pain: _____
- Injections to treat painful areas
- Transplant Surgery
- Abdominal Surgeries
- Heart Surgery
- Other Surgery or Procedure _____

Mental Health

- Panic Disorder
- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Alzheimer's Disease
- Dementia
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- ADD/ADHD
- Suicidal thoughts, plans, or attempts
- History of abuse
- History of drug abuse
- Other _____

THIS SECTION FOR WOMEN ONLY:

- Could you be pregnant: YES NO
- Taking hormones
- Using oral contraceptive
- Pelvic Inflammation Disease
- Hysterectomy Full Partial Date: _____
- Ovaries Removed Date: _____
- Heavy Periods
- PMS or PMDD

- Trying to get pregnant YES NO
- Currently taking birth control
- Decreased Libido
- Hot Flashes
- Tubal Ligation Date: _____
- Natural Post Menopause Date of Last Period: _____
- Irregular Periods
- Other _____

THIS SECTION FOR MEN ONLY

- Decreased Libido
- Prostate Enlargement
- Problems Urinating
- Erectile Dysfunction
- Other _____

I certify that the above information is true and accurate to the best of my ability.

Signature (Required)

Date:



YOUR FOLLOW-UP CARE

Please call us within 30 days to inform us how the program is working for you. As always, our business staff is available 5 days a week to answer any questions you may have. You can also email us at ask@michiganholistichealth.com. We expect to provide follow-up care to you to monitor the efficacy of your medical use of marijuana.

As of April 1, 2013, the state is issuing two-year cards. However court cases in Michigan have held that a registry card—even one verified by the state—does not prove “ongoing” contact between the physician and patient.

For your protection, Michigan Holistic Health will need an annual appointment with you to maintain your doctor-patient relationship as required by the state. The charge for this annual appointment next year will be \$75. We will review and assess your medical history and current medical conditions to determine that you are still likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat your condition. We will also discuss how well the program is working for you and offer recommendations for any additional care, such as alternative therapy.

Patient Name (please print)

Date of birth

Patient signature

Today's Date

THE PHYSICIAN MUST INITIAL EACH LINE BELOW:

I do hereby declare that the written certificate was prepared in the course of a bona fide physician-patient relationship in which each of the following were present as part of the treatment or counseling relationship:

- _____ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))
- _____ I have created and will maintain records of this patient's condition in accord with medically accepted standards.(MCL333.26423(a)(2))
- _____ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))
- _____ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's Primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition(MCL333.26423(a)(4))



“No marijuana-related legal action pending” Agreement

By signing below, I, _____, assert that

as of today, the _____ day of _____ in the year _____,

I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act’s affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Michigan Holistic Health, PLLC at the time of service.

I also further assert that any and all information I give pertaining to my “qualifying condition” as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Michigan Holistic Health, PLLC harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Michigan Holistic Health PLLC – a Michigan Corporation.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Michigan Holistic Health, PLLC



Physician Release from all Liability Form

Signing this form releases the physicians of Michigan Holistic Health from all liability for providing a state of Michigan medical marijuana “Physician’s Certification.” And by signing this form, you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, the physicians of Michigan Holistic Health cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume nor can they, in any way, help or tell you how to acquire or grow it. Please consult the internet or your local compassion club.
3. The physicians of Michigan Holistic Health may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.
4. The physicians of Michigan Holistic Health cannot provide you with a regimen for the use of medical marijuana. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. Please take care if you have not used marijuana before. You are advised to keep a log of how much medicine you use and its effects on your symptoms. This will help you make adjustments to your dose and frequency.
6. You are in charge of the most comfortable and effective method of delivery – vaporizer, topicals, smoking or edibles. (It is not advisable for patients with lung issues or smoke allergies to smoke marijuana.) These are general guidelines and should be used in conjunction with your own common sense and wisdom about your health.
7. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.
8. Medical marijuana is generally tolerated well by patients. Any side effects tend to be mild and temporary, usually lasting one week or less as patients adjust. Common side effects include irritated throat, dry mouth, elevated heart rate, mild time and space disorientation, mild euphoria, a general sense of well-being, and in some instances drowsiness and amotivation.

I, _____, agree not to make any legal claim or complaint, or commence any proceeding against Michigan Holistic Health & Assoc. in providing me with a “Physician’s Certification” as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form.

Signature of applicant

Date

Signature of witness

Date



Michigan Medical Marihuana Program
Application Form for Registry Identification Card

(517) 284-6400 | www.michigan.gov/mmp

For Official Use Only

MMP 3501 (Rev. 1/15)

- \$60 Patient (with no caregiver) Fee Received
- \$85 Patient (with caregiver) Fee Received

Section A: Patient Information (REQUIRED) as it appears on your identification

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)
4. Patient Registry ID Card Number (For Renewals Only) P		5. MI Driver's License# or MI ID Card #	6. Date of Birth (MM/DD/YYYY)
7a. Mailing Address		7b. Apartment/Suite/Lot #	
8. City	9. State MI	10. Zip Code	
11. Email Address (If provided, you agree to receive email correspondence from MMMP)		12. Telephone Number	

Section B: Person Allowed to Possess Patient's Marihuana Plants: (REQUIRED)

13. Plant possession: You must select one box. Failure to do so will result in the denial of your application.

- SELECT ONLY ONE:**
- I will possess the plants
 - My caregiver will possess the plants

Section C: Caregiver Information (If the patient is designating a caregiver)

14. Legal First Name	15. Middle Initial	16a. Legal Last Name	16b. Suffix (Jr., Sr., III, etc.)
17. Caregiver Registry Card ID Number (For Renewals Only) C		18. MI Driver's License# or MI ID Card #	19. Date of Birth (MM/DD/YYYY)
20a. Mailing Address		20b. Apartment/Suite/Lot #	
21. City	22. State MI	23. Zip Code	
24. Email Address (If provided, you agree to receive email correspondence from MMMP)		25. Telephone Number	

26. Other Names Used by Caregiver (Nicknames, maiden names etc. Use a separate piece of paper if you need space for additional names)

Section D: Caregiver Patient Signature & Date (Required)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 et seq.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Patient/Applicant: **X** _____ Date: _____

Signature of Caregiver: **X** _____ Date: _____