MEDICAL QUESTIONNAIRE

Date_____

Please answer these questions as completely as you can.
We realize this form is long, but the information is extremely valuable to us in providing the best possible care.

Patient name _____
Last First Middle

Phone _____ Date of birth _____

Patient's occupation _____

Emergency contact _____

Relationship to patient _____

Phone number/s _____

If you were referred, who told you about Michigan Holistic Health? (please circle)

Physician _____ Family/Friend _____

Compassion Club _____ Other _____

If you heard or saw advertising or a news story, please tell us where – all that apply.

__ Newspaper article __Print ad __ TV ad __ Radio ad

__ Media interview __ Billboard __ Internet / website

Please check whether if you'd like a list of free/low cost clinics **__ YES __ NO**

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

Michigan **Holistic Health**

PLEASE PROVIDE THE NAME OF YOUR PRIMARY CARE PHYSICIAN, IF YOU HAVE ONE

Physician or Practice name _____

City, state _____

Phone # _____
Area code

FAX # (if available) _____
Area code

Please check whether you'd like us to send your records from our office to your physician

(*fax # required*)

__ YES __ NO

I request and authorize Michigan Holistic Health to fax my medical records to the doctor/practice named.

Patient's name: _____ Date of birth _____

Patient's phone/s _____

Signature _____ Date _____

To the primary care physician/practice:

We are sending these records as a courtesy to our mutual patient.

Please call with any questions: 855-420-8100.

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT'S SIGNED

New 4/2013

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.)
(Do NOT include eye conditions that you have previously listed.)

Condition Month/year diagnosed

_____

_____

_____

_____

_____

Please list all previous surgical procedures (not involving eyes) and their dates (if known):

Surgical Procedure Month/year

_____

_____

_____

_____

_____

MEDICATIONS:

Please list all medications that you are currently taking and their dosage (if known):

Medication Dose # of times per day For how long

_____

_____

_____

_____

_____

Are you taking aspirin or any other over-the-counter medicines? No ___ Yes ___

If yes, please list: _____

_____

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

If yes, please list: _____

_____

_____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	NO	YES
General		
Fever	___	___
Unexplained weight loss	___	___
Night sweats	___	___
Ear, nose, or throat		
Ringing in ears	___	___
Hearing Loss	___	___
Pain	___	___
Nervous System		
Headache	___	___
Stroke	___	___
Seizure/epilepsy	___	___
Weakness, numbness, tingling	___	___
Heart or circulatory problems		
Heart attack or heart failure	___	___
Irregular heart rhythm	___	___
Chest pain	___	___
Pacemaker	___	___
Hypertension	___	___
Endocrine		
Thyroid disease	___	___
Diabetes	___	___
Hormonal disease	___	___
Allergy/Immunology		
Environmental allergies	___	___
Iodine allergy	___	___
Contrast material (dye) allergy	___	___
Cat scratch or cat bite	___	___
Skin/breast		
Masses/tumors	___	___
Rash	___	___
Discharge from breast	___	___

	NO	YES
Lungs/Breathing		
Breathing difficulty	___	___
Asthma	___	___
Lung disease	___	___
Digestive System		
Diarrhea	___	___
Ulcer disease	___	___
Hepatitis	___	___
Genitourinary		
Kidney disease	___	___
Urinary tract infection	___	___
Urinary bleeding	___	___
Altered menses	___	___
Blood		
Anemia (low blood count)	___	___
Blood tumors/disease	___	___
Swollen glands	___	___
Bleeding disorder	___	___
Musculoskeletal		
Joint pain/arthritis	___	___
Fractured bones	___	___
Pain with chewing	___	___
Scalp pain/tenderness	___	___
Psychiatric		
Depression	___	___
Mood swings	___	___
Anxiety	___	___
Admission to hospital/ psychiatric illness	___	___

Other:

_____

_____

COMMENTS: _____

_____

_____

SF-12® Health Survey

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

---

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
○	○	○	○	○

---

2. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
b Climbing <u>several</u> flights of stairs	○	○	○

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3. During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	Yes	No
a <u>Accomplished less</u> than you would like	○	○
b Were limited in the <u>kind</u> of work or other activities	○	○

---

4. **During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

		Yes	No
a	Accomplished less than you would like	☐	☐
b	Did work or other activities less carefully than usual	☐	☐

Patient's initials _____

5. **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

---

6. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a	Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b	Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c	Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

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7. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Patient's initials _____

"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 and cannot in any way help or tell you how to acquire or grow it.

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. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.

6. 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 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

MMP 3501 (Rev. 4/13)

Department of Licensing and Regulatory Affairs
Michigan Medical Marihuana Registry
P.O. Box 30083, Lansing, MI 48909
517-373-0395 · www.michigan.gov/mmp

FOR OFFICIAL USE ONLY

APPLICATION FORM

for Registry Identification Card

- *For Applicants/Patients 18 years of age or older*
- Please call our office if you have any questions
- Submit ALL documents in ONE envelope
- We recommend the applicant/patient submit the application packet
- Type or print legibly

PROOF OF MICHIGAN RESIDENCY IS REQUIRED

☐ NEW: I have **never applied** before or my registry ID card is **expired** ☐ RENEWAL: My current registry ID card is **not** expired

For Renewals: Check any Changes: ☐ Patient Address Change ☐ Caregiver Address Change ☐ Plant Possession
☐ Patient Adding or Changing to New Caregiver (List the new caregiver's information in Section B)
☐ Patient Name Change ☐ Caregiver Name Change (Documents required for name changes; see question #2 on page 2)

Section A: APPLICANT/PATIENT INFORMATION: *(REQUIRED)*

For Renewals: Current Card Registry ID Card Number: P_____ ☐ Male ☐ Female

Legal Name (First):_____ (MI):_____ (Last):_____

Social Security Number:_____ Date of Birth:_____

Mailing Address:_____ (if applicable) Apt/Lot #_____

City:_____ Zip:_____ Phone Number (with area code):_____

Alternate Phone Number (with area code):_____

A patient who is 18 years of age or older is not required to designate a caregiver

► To add or change to a new caregiver or retain your current caregiver, you must complete Section B and refer to questions #8-9 on page 2.

► Leave Section B blank ONLY if you are NOT designating a caregiver.

Section B: PRIMARY CAREGIVER INFORMATION: *(IF APPLICABLE)*

For Renewals: If already registered to this patient, Current Registry ID Card Number: C_____ ☐ Male ☐ Female

Legal Name (First):_____ (MI):_____ (Last):_____

Social Security Number:_____ Date of Birth:_____

Mailing Address:_____ (if applicable) Apt/Lot #_____

City:_____ Zip:_____ Phone Number (with area code):_____

Alternate Phone Number (with area code):_____

Plant possession will default to the Applicant/Patient if neither or both boxes are checked in Section C.

Section C: PERSON ALLOWED TO POSSESS PATIENT'S MARIHUANA PLANTS: *(REQUIRED)*

SELECT ONLY ONE: ☐ APPLICANT/PATIENT <-------- OR --------> ☐ PRIMARY CAREGIVER

MMP 3501 (Rev. 4/13)

Michigan Medical Marihuana Registry
APPLICATION FORM

To ensure this application is complete, the Applicant/Patient must answer YES to all of the applicable questions below:

1. Did you, the applicant/patient, answer all of the fields correctly and legibly in Section A?..... ☐ YES

2. For renewals, is a copy of documentation provided for a name change? (if applicable)
(I.e., marriage/divorce decree, legal name change document, valid MI driver license or Michigan ID, etc)..... ☐ YES

3. Are all of the fields for the caregiver answered correctly and legibly in Section B (if applicable)
(if you, the patient, designated a caregiver)?..... ☐ YES

4. Is only one box checked in Section C for person who is allowed to possess the patient's Marihuana plants?..... ☐ YES

(if #5 is NO, #6 must be YES)

5. Did you, the *applicant/patient,* sign and date this application in Section D below?..... ☐ YES ☐ NO

6. OR, is a copy of a Durable Power of Attorney for Health Care or legal guardianship with (if #6 is NO, #5 must be YES)
signatory authority provided, if the applicant/patient is unable to sign this application?..... ☐ YES ☐ NO

7. Is a valid, clear copy (front and back) of the ***applicant/patient's*** Michigan driver license or Michigan ID provided OR your photo ID and Michigan voter registration provided?..... ☐ YES

8. Is a valid, clear copy (front and back) of the ***caregiver's*** Michigan driver license or Michigan ID provided OR his/her photo ID and Michigan voter registration provided (if you, (if applicable)
the applicant/patient, designated a caregiver in Section B)?..... ☐ YES

9. Is a copy of the Caregiver Attestation, correctly and legibly completed by the caregiver, provided (if applicable)
(if you, the applicant/patient, designated a caregiver in Section B)?..... ☐ YES

10. Is the Physician Certification provided?..... ☐ YES

(if #11 is NO, #12 must be YES)

11. Is the $100.00 Registration Fee included, payable to State of Michigan-MMMP?..... ☐ YES ☐ NO

Enter the $100.00Check or Money Order #_____

12. OR, if you are eligible for the reduced fee, is the $25.00 Registration Fee included, (if #12 is NO, #11 must be YES)
payable to State of Michigan-MMMP? (Additional documents required-See #13)..... ☐ YES ☐ NO

Enter the $25.00 Check or Money Order #_____ (if applicable)

13. Is the acceptable supporting documentation for the reduced fee included?..... ☐ YES
Examples of acceptable supporting documentation for the reduced fee are available at www.michigan.gov/mmp.

14. Check the program you, the applicant/patient, are currently enrolled in which qualifies you for the reduced fee:
☐ Full Medicaid ☐ Social Security Disability ☐ Supplemental Security Income (SSI)

15. Make a copy for your records and mail only one complete application, the check or money order, and all required documentation in one envelope to: Michigan Medical Marihuana Registry Program · PO Box 30083 · Lansing, MI 48909

Section D: APPLICANT/PATIENT SIGNATURE & DATE: *(REQUIRED)*

By signing below, I attest that the information I have entered on this application is true and accurate:

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

WHAT TO EXPECT AFTER YOU SUBMIT YOUR APPLICATION:

1. When your application is received by our office it will be approved or denied within 15 business days.
2. If this application is denied, the patient will receive a certified letter of explanation. You can then resubmit a copy of the application, with all required documents, for reconsideration up to 2 years from the date the fee is received.
3. If this application is approved, it will be processed in the date order received. The patient, and caregiver if designated, will be issued and sent a registry ID card to the mailing address provided on this application.
4. If you have not received a denial letter, an approval letter, or some form of notification within six (6) weeks from the date the MMP receives your valid application, please contact our office at 517-373-0395 and select option #3. Please allow a full 6 weeks.
5. After submitting this application, any changes to your record (address, caregiver, name, etc.), prior to your registry ID card's expiration, should be submitted on a Change Form with the required fee. We recommend not submitting a Change Form within 60 days of submitting your renewal application.