6499 38th Ave. N. Suite C1
St. Petersburg, FL 33710

COMPASSIONATE CARE CLINICS OF PINELLAS

Office: 727-440-7786
Fax: 727-685-1833

New Patient Demographics

Name: ____ Date of Birth: ____________________
(Last) **(First)** **(MI)** **(Month/Day/Year)**

Mailing Address: ____
(Street/Apt.) **(City)** **(State)** **(Zip Code)**

Phone #: _________________________ * E-mail address: ___________________________________

Driver's License #: _____________________________ Social Security #: _________________________

Please circle one:
Gender: M / F If female, are you pregnant or at risk of becoming pregnant? Y / N

Marital Status: Single / Married / Widowed / Divorced Spouses Name: _____________________________

Children: Y / N How many:__________________ Ages: ______________________

Do you use tobacco? Y / N How much: _________________ How many years: _______________

Do you drink alcohol? Y / N How much: _________________ How often: __________________

Reason for cannabis treatment? **(If condition is not listed please select other medical condition and explain.)**
Please check any that apply:

Cancer _____ Epilepsy _____ Glaucoma _____

PTSD _____ HIV/AIDS _____ ALS (Lou Gehrig's Disease) _____

Crohn's Disease _____ Parkinson's Disease _____ Multiple Sclerosis _____

_____ Other medical condition of like kind or class with symptoms comparable to those listed above.

Explain (if other):

____

____

Diagnosing Physician or Specialist: ____________________________ Phone #: ____________________

***E-mail address must be provided. Communication from the Medical Marijuana Use registry will come by e-mail.**

Name: Date of Birth:

Previous Medical History

Please list all symptoms you experience, frequency, severity, and duration:
(Ex: muscle spasms, severe nausea, vomiting, anxiety, depression, panic attacks, chest pain, loss of appetite, insomnia, abdominal pain, exhaustion, restlessness, fatigue, constipation, nerve pain, back pain, severe menstrual cramps, loss of motor control, tremors or shaking of arms and limbs, dizziness, fainting, unstable mood, speech difficulty, etc…)

Symptom	Frequency (How often?)	Severity (1-10)	Duration (How long?)

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

Please list all treatments you have tried, how long each treatment was attempted, and the outcomes of each treatment:

Treatment	Duration	Outcome

1. ______
2. ______
3. ______
4. ______
5. ______

Please list all current medications to include name of medication, dose, and frequency:

Medication	Dose	Frequency

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

Name: Date of Birth:

Previous Medical History

Please list any previous hospitalizations in the past 24 months:

Reason **Date**

1. ____
2. ____
3. ____
4. ____
5. ____

Please list any previous surgery or procedures done in the past 24 months:

Reason **Date**

1. ____
2. ____
3. ____
4. ____
5. ____

I request that medical information, test results, or messages:
(**Initial all below that apply**)

_______ Be given to me directly in person or over the phone.
_______ Be left on my home/cell answering machine or voicemail.
_______ Be left with a member of my household. Name: ________________________________

The above information is true and correct to the best of my knowledge. I have not made any false statements or misrepresentations. I consent to medical treatment. I understand that I am financially responsible for all charges incurred and required to pay when services are rendered.

____ ______________________________
Patient/Guardian Signature **Date**