

The Bien Etre Center

Personal Information

Date_____

Name_____ Date of Birth_____ Age_____

Height_____ Weight_____ Gender: Male / Female

Address_____ City_____ State/Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Medical History

Current medical complaint: (List the medical problems for which you use or would like to use medical marijuana; please provide details. Let us know if you need more space.)

Who takes care of you for your medical problems (doctor, chiropractor, acupuncturist, massage therapist, psychologist or counselor, etc.)? Please give the name and tell us when you were last seen.

Medications: List all of your medications (include prescription, herb, and over-the-counter).

List any medication you are allergic to:_____

Other treatments: Check any other treatments you use for your condition:

surgery physical therapy chiropractic massage herbal therapy
 counseling exercise other _____

Medical History (continued)

Do you have or have you ever had any of the following medical problems?

Asthma/Lung Disease Cancer HIV/AIDS Diabetes Hepatitis
 Epilepsy/Seizures Stroke Liver Disease Kidney Disease High Blood
Pressure Heart Disease Sleep Disorders (sleep apnea, insomnia) Substance Abuse
 Intestinal Disorders (IBS, ulcers) Multiple Sclerosis
 Mental health problems ADD/ADHD

Female Patients Only:

Are you pregnant? Yes/No Are you currently breastfeeding? Yes/No

Surgical History

Please list the surgeries that you have had:

Drug and Alcohol History

Do you currently use: Tobacco Yes/No number of cigarettes per day _____

Alcohol: Yes/No number of drinks per week _____

Other substance use history:

Cocaine/Meth
 Opiates/Prescription opiates/heroin/methadone
 Hallucinogens/ecstasy/LSD/mushrooms
 None

Would you like help quitting? Yes / No / NA

Marijuana History (Continued)

Have you been evaluated by another physician for medical marijuana? Yes/No

If yes, where and

when: _____

Do you use marijuana to reduce or eliminate the use of any medications that have been prescribed for your medical condition? Yes/No

If yes, which medication have you reduced or eliminated and why?

How often do you use marijuana?

___ everyday or almost every day

___ about 1-2 times per week

___ more than once a month

What is your preferred method of using marijuana?

___ smoke ___ vaporizer ___ ingested ___ topical

How effective is marijuana for your medical problem?

___ very effective ___ effective ___ only somewhat effective

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Patient Signature

Date

The Bien Etre Center

Important Patient Acknowledgments

By signing this page, you are acknowledging that:

- The physician, staff, and/or representatives of The Bien Etre Center are neither providing nor dispensing medical marijuana.
- The Bien Etre Center's physician will NOT be providing or discussing information regarding dispensary, co-op, delivery service, or any other way to obtain marijuana.
- The physician, staff, and representatives of The Bien Etre Center are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.
- Should an approval be made for my medical use of cannabis, there is a renewal date specified by the physician. It is my responsibility to see the physician to re-evaluate possible continuance of cannabis use beyond the term of the approval.
- I am a resident of Arizona and have not misrepresented any information to The Bien Etre Center.
- I am not an agent of law enforcement, state, or federal government here for the purpose of investigation or entrapment.
- I am not recording any portion of my visit with The Bien Etre Center nor do I possess any recording equipment. I understand The Bien Etre Center does not approve such action.

Patient Signature: _____ Date: _____

The Bien Etre Center

Informed Consent

By signing below, you acknowledge that you have been informed of and understand the following:

I am being evaluated for a physician's recommendation for marijuana. The physician will make this determination based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I must be a Arizona resident to obtain an approval or recommendation for the use of cannabis (medical marijuana) under Arizona's AMMA (A.R.S. Title 36, Chapter 28).

Marijuana has not yet been approved by the Food and Drug Administration. Therefore, marijuana sold for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The use of marijuana can affect coordination, motor skills, and cognition, i.e., the ability to think, judge, reason and act. While using marijuana, I should not drive, operate heavy machinery, or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression, and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space, and impair my judgment.

I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

I understand that I may contact my primary care physician or 911 if I experience any of these side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or (continued)

INFORMED CONSENT (continued):

experience crying spells. I will also contact my primary care physician or 911 if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema, and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth, and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician. The physician will inform me of alternatives to smoking marijuana.

The risk, benefits, and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact my primary care physician or seek professional help. Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances, and unusual tiredness.

Symptoms of marijuana overdose include, but are not limited to: nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms, or legs, anxiety attacks, and incapacitation. If I experience these symptoms, I should contact my primary care physician, dial 911 or go to the nearest emergency room.

If The Bien Etre Center subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may be revoked. I agree to promptly meet with and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

I will have the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

Patient Signature: _____ Date: _____

The Bien Etre Center

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have been made aware of the Notice of Privacy Practices for The Bien Etre Center. I understand that I may obtain additional copies upon request, as described in the Notice.

This Acknowledgement will be filed with my records.

Patient Name (print): _____

Patient Signature: _____

Date: _____