HEALTH HISTORY QUESTIONNAIRE - Page 1

THCF Medical Clinic
2712 NE Sandy Blvd.
Portland, OR 97232
503.235.4606

New Patient: ____ Returning Patient: ____

Identifying Data **Please write legibly!**

Last Name: _____ First Name: _____ MI: ____

Date of Birth: ____/____/_____ Age: _____ Gender: M ____ F ____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Alternate Phone: _____

E-mail: _____

Emergency contact: _____ Phone: _____ Relationship: _____

How did you first hear of the THCF Medical Clinic? _____

Release of Liability

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or am interested in finding whether medical marijuana (referred to here as cannabis) provides substantial relief and improvement in my condition.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities, and/or contaminants. In requesting a permit for the use of this plant as medication, I assume full responsibility for any and all risks of this action.

I am advised that cannabis smoke contains chemicals known as tars that may be harmful to my health. Recent research indicates that the vaporization of cannabis eliminates exposure to tar, carbon monoxide, and carcinogens. Should respiratory problems or other ill effects be experienced in association with its use, it should be discontinued and reported to the physician.

I am advised that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. There may be other risks that are not addressed herein. I assume full responsibility for any harm to me and/or other individuals as a result of my use of cannabis.

State medical marijuana law provides for the possession and cultivation of cannabis, for the personal medical purposes of the patient, with a physician's statement. The physician, staff, and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in obtaining cannabis.

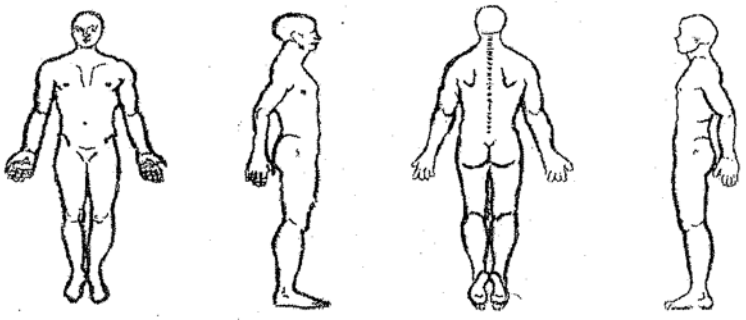
I, the undersigned, hereby request a consultation with the physician for the purposes of determining the appropriateness of medical cannabis treatment. The physician, staff, and representatives are addressing specific aspects of my medical care, and, unless otherwise stated, are in no way establishing themselves as the primary care provider. Should my medical use of cannabis be approved, I understand there is a renewal date specified. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of approval. Furthermore, the undersigned, my heirs, assigns, or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees free of and harmless from any liability resulting from the use of cannabis.

I hereby authorize THCF Medical Clinic and its representatives to confirm my status as a current patient when requested to do so by law enforcement or patient service organizations.

Signature: _____ **Date:** _____

HEALTH HISTORY QUESTIONNAIRE - Page 2

Pain Inventory: On the diagram below, shade the areas where you feel pain. Put an X on the area that hurts the most.



Front Right Back Left

Primary Medical Complaint:_____

_____

_____

Medication Allergies:

_____ _____

_____ _____

Past Surgical History:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Past Medical History (check box) Do you have any problems with the following:

___ High blood pressure
___ HIV/AIDS
___ Breast lesions
___ Diabetes
___ Back and neck pain
___ Cachexia
___ Migraine headaches
___ Multiple sclerosis
___ Prostate disease
___ Blood disorders
___ Substance abuse
___ Cancer, specify: _____
___ Chronic pain, specify: _____
___ Brain disorders (epilepsy, trauma, etc)
___ Dystonia (spasms, tremors, Parkinson's)
___ Kidney disorders (cystitis, renal failure)
___ Liver disease (cirrhosis, hepatitis B or C)
___ Lung disease (asthma, emphysema)
___ Mental disorders (depression, anxiety)
___ Ear problem (tinnitus, hearing loss)
___ Eye problems (glaucoma, cataracts)
___ Weight loss/gain
___ Intestinal disorders (ulcers, colitis, IBS)
___ Herpes zoster/shingles/other
___ Circulation (stroke, phlebitis, etc)
___ Eating disorder (anorexia, bulimia)
___ Rheumatic disease (arthritis, lupus)
___ Endocrine problems (thyroid, hormones)
___ Genital/gynecological problems
___ Skin disorders (psoriasis, eczema)
___ Sleep disorders (insomnia, sleep apnea)
___ Heart disease
___ Other

Please list all your current medications.

_____

_____

_____

_____

Patient Acknowledgment of THCF Medical Clinic Notice of Privacy Practices
A copy of the Notice of Privacy Practices is available to me by the front desk.

_____ _____
Patient Name (print) Name of authorized representative (if applicable)

_____ _____
Patient Signature (or authorized representative) Date