



## MEDICAL MARIJUANA OF ORANGE COUNTY

First Name:	MI:	Last Name:
Drivers License:	State ID Card:	DHS ID:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Phone:	Email:	
Street Address1:		
Street Address2:		
City:	State: <input type="checkbox"/> Ca	Zip:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF PARENT OF GUARDIAN  
IF PATIENT IS UNDER AGE 18**

\_\_\_\_\_  
**PRINT NAME OF PARENT/GUARDIAN  
IF PATIENT IS UNDER AGE 18**

FOR OFFICE USE ONLY: <input type="checkbox"/> NEW PATIENT <input type="checkbox"/> RETURNING PATIENT	
<input type="checkbox"/> DX1: CERTIFYING PROVIDER:	<input type="checkbox"/> DX2: CERTIFYING PROVIDER:
<input type="checkbox"/> DX3: CERTIFYING PROVIDER:	<input type="checkbox"/> DX4: CERTIFYING PROVIDER:
CHECK BOXES IN SPACES ABOVE IF MEDICAL RECORDS WERE PROVIDED FOR DX LISTED	
EXPIRATION:	

# PATIENT INTAKE MMOC

<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>
<b>Date of Birth:</b>		
<b>DRUG ALLERGIES:</b> Do you have any drug allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If you have any Drug allergies, please list them in the table below.		
<b>Drug</b>	<b>What was your reaction:</b>	
1.	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> almost died <input type="checkbox"/> other:	
2.	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> almost died <input type="checkbox"/> other:	
3.	<input type="checkbox"/> Rash <input type="checkbox"/> Swelling <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> almost died <input type="checkbox"/> other:	
<b>CURRENT MEDICATION LIST:</b> Please list all medications you are CURRENTLY taking below.		
1.	2.	3.
4.	5.	6.
<b>MEDICAL PROBLEMS:</b> Please list the problems from which you are seeking relief with medical marijuana:		
1.	<input type="checkbox"/> I have seen a doctor for this condition <input type="checkbox"/> I have records today <input type="checkbox"/> I can get records	
2.	<input type="checkbox"/> I have seen a doctor for this condition <input type="checkbox"/> I have records today <input type="checkbox"/> I can get records	
3.	<input type="checkbox"/> I have seen a doctor for this condition <input type="checkbox"/> I have records today <input type="checkbox"/> I can get records	
4.	<input type="checkbox"/> I have seen a doctor for this condition <input type="checkbox"/> I have records today <input type="checkbox"/> I can get records	
5.	<input type="checkbox"/> I have seen a doctor for this condition <input type="checkbox"/> I have records today <input type="checkbox"/> I can get records	
6.	<input type="checkbox"/> I have seen a doctor for this condition <input type="checkbox"/> I have records today <input type="checkbox"/> I can get records	
Please place a check mark <input checked="" type="checkbox"/> next to each of the medical problems listed below from which you suffer.		
<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> OCD <input type="checkbox"/> PTSD <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar <input type="checkbox"/> Phobias <input type="checkbox"/> _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteo <input type="checkbox"/> Psoriatic <input type="checkbox"/> Low back pain <input type="checkbox"/> Sciatica <input type="checkbox"/> Mid back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Blood Disorders: <input type="checkbox"/> anemia <input type="checkbox"/> abnormal clotting <input type="checkbox"/> Brain disorders <input type="checkbox"/> epilepsy <input type="checkbox"/> seizures <input type="checkbox"/> severe head injury <input type="checkbox"/> Breast lesions <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma: specify: <input type="checkbox"/> Chronic pain, specify location: _____ <input type="checkbox"/> RSD <input type="checkbox"/> Circulation (stroke, phlebitis) <input type="checkbox"/> Diabetes <input type="checkbox"/> Diabetic neuropathy <input type="checkbox"/> Dystonia <input type="checkbox"/> muscle spasms <input type="checkbox"/> tremors <input type="checkbox"/> Parkinson's <input type="checkbox"/> Ear problems <input type="checkbox"/> tinnitus <input type="checkbox"/> hearing loss <input type="checkbox"/> Eating disorder: <input type="checkbox"/> anorexia <input type="checkbox"/> bulimia <input type="checkbox"/> chronic nausea <input type="checkbox"/> Endocrine problems (thyroid, hormones) <input type="checkbox"/> Eye problems <input type="checkbox"/> glaucoma <input type="checkbox"/> GYN: <input type="checkbox"/> Painful periods <input type="checkbox"/> PMS <input type="checkbox"/> Menopausal problems <input type="checkbox"/> Heart disease <input type="checkbox"/> Angina <input type="checkbox"/> enlarged heart <input type="checkbox"/> Heart attack	<input type="checkbox"/> Herpes zoster/shingles/other <input type="checkbox"/> High blood pressure <input type="checkbox"/> HIV positive <input type="checkbox"/> AIDS <input type="checkbox"/> Intestinal disorders: <input type="checkbox"/> Chron's <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> GERD <input type="checkbox"/> Kidney disease (cystitis, renal failure) <input type="checkbox"/> Liver disease: <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Lungs disease: <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Cluster <input type="checkbox"/> Tension <input type="checkbox"/> TMJ <input type="checkbox"/> Multiple sclerosis (neurodegenerative disease) <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Prostate enlargement <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Rheumatic disease: <input type="checkbox"/> Lupus <input type="checkbox"/> Sjogrens <input type="checkbox"/> Reiters <input type="checkbox"/> Skin disorders <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> _____ <input type="checkbox"/> Sleep disorders: <input type="checkbox"/> insomnia <input type="checkbox"/> sleep apnea <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> other:	
<b>List any surgeries you have had and the approximate date in the boxes below.</b>		
<b>Do you abuse Street Drugs (do not include marijuana)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If you answered yes, please place a "✓" next to each of the drug(s) you have abused.</b>		
<input type="checkbox"/> Heroin <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Cocaine <input type="checkbox"/> Other _____ Are you currently using? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever used cannabis before?  Yes  No

If you have used cannabis, how long have you been doing so? \_\_\_\_\_  Yrs  Months

How often:  \_\_\_\_\_ times daily,  \_\_\_\_\_ times weekly,  \_\_\_\_\_ times monthly  Rarely  Years ago.

Have you ever used Cannabis for the symptoms that brought you here today?  Yes  No

If you have used cannabis for the symptoms that brought you here, did it help?  Yes  No

Have you ever used cannabis recreationally?  Yes  No

<b>STAFF USE ONLY:</b>	<b>BP:</b> /	<b>PULSE:</b>	<b>Date:</b>
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ACKNOWLEDGMENT AND CONSENT  
MEDICAL MARIJUANA ORANGE COUNTY

Initials

\_\_\_\_\_ I voluntarily consent to receive medical and health care services from Medical Marijuana of Orange County, Bob E. Blake, M.D.

\_\_\_\_\_ I have been assured that records relating to my care will be kept confidential and that no information will be released or printed that would disclose personal identity, unless required by law.

\_\_\_\_\_ I authorize MMOC and **Dr. Blake to verify that I have received a recommendation to use medical marijuana** to Law Enforcement officials, dispensaries and coops.

\_\_\_\_\_ I understand that I must be a California State resident to obtain an approval or recommendation for the use of cannabis. Non-California residents are not able to use medical marijuana while in California under California's Compassionate Use Act of 1996 (Health & Safety Code #11362.5).

\_\_\_\_\_ I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of marijuana as a drug and understand the significance of this fact.

\_\_\_\_\_ I consent to using marijuana only for the treatment of the symptoms stated in the medical declaration.

\_\_\_\_\_ I am aware that medical cannabis has not been approved under Federal Regulations and I understand that **Medical Marijuana has not been deemed legal under federal law.**

\_\_\_\_\_ I understand the potential risks associated with the use of medical marijuana, including, but not limited to, the effect on my cardiovascular and pulmonary systems (heart and lungs), psychomotor performance, risks associated with the long-term use of marijuana, as well as **potential drug dependency.**

\_\_\_\_\_ I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified; **I accept those risks.**

\_\_\_\_\_ I accept all the aforementioned risks and will not hold MMOC or Bob E. Blake, M.D. responsible for any legal ramifications.

\_\_\_\_\_ Furthermore, I, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold the physician and his/principals, agents, and employees, free of and harmless from any liability resulting from the my use of cannabis.

\_\_\_\_\_ I attest that the information I have submitted to MMOC is correct and any medical history presented to the doctor is also factual and complete. I attest that the information on this form is correct and any medical history presented or discussed with the doctor is also factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical cannabis.

\_\_\_\_\_ I affirm that I am a California state resident and that I have a serious medical condition that adversely affects my quality of life. I have found, or am interested in finding whether cannabis (medical marijuana) provides substantial relief and improvement in my condition.

\_\_\_\_\_  
PLEASE PRINT YOUR NAME

\_\_\_\_\_  
PRINT NAME OF PARENT/GUARDIAN  
IF PATIENT IS UNDER AGE 18

**X**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OF GUARDIAN  
IF PATIENT IS UNDER AGE 18

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
at the Office of Bob E. Blake, M.D. and Methods of Communication  
Between You (patient) and Bob E. Blake, M.D.

In general, the HIPAA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative mean as sending correspondence to the individuals office instead of the individuals home. The Privacy Rule generally requires health care providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an author requested by the individual in person. I hereby acknowledge that I have read the Notice of Privacy Practices ('Notice') was given to me upon arrival at Dr. Bob Blake's office.

**For matters such as appointment reminders and other Protected Health Information, I wish to be contacted in the following ways (CHECK ALL THAT APPLY):**

**HOME TELEPHONE** - IT IS OK TO CALL MY HOME PHONE.

Phone number: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

It is Ok to leave message to call back the office of Dr. Bob Blake on my home phone.

It is OK to leave message with detailed information on my home phone.

**CELL TELEPHONE** - IT IS OK TO CALL MY CELL PHONE.

Phone number: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

It is Ok to leave message to call back the office of Dr. Bob Blake on my cell phone.

It is OK to leave message with detailed information on my cell phone.

**WORK TELEPHONE** - IT IS OK TO CALL MY WORK PHONE.

Phone number: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

It is Ok to leave message to call back the office of Dr. Bob Blake on my work phone.

It is OK to leave message with detailed information on my work phone.

**MAIL (USPS)**

Okay to send mail to my **home** address

Street Address: \_\_\_\_\_ Apt \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Okay to send mail to my **work** address. If Yes;

Send to: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ok to send **email** to the following email address: \_\_\_\_\_@\_\_\_\_\_

Ok to send fax to the following **Fax number**: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

**X** \_\_\_\_\_

Signature

Note: if patient is a minor, parents/legal guardian must read and sign above

# POSSIBLE SIDE EFFECTS OF MEDICAL MARIJUANA MMOC

“MEDICAL MARIJUANA” (MEDICINAL CANNABIS, CANNABIS, TETRAHYDROCANNABINOLS)

## CONTRAINDICATIONS:

Hypersensitivity to tetrahydrocannabinol or dronabinol products hypersensitivity to sesame oil

## PRECAUTIONS:

**Cardiac disorders** such as arrhythmias, cardiac ischemia (usually manifest as either angina or a heart attack), concomitant **use of sedatives or other psychoactive drugs, elderly patients** may be more sensitive to psychoactive effects, **history of substance abuse**, history of **psychiatric illness**.

**Do not drive, operate machinery, or engage in hazardous activities.**

**Do not use during pregnancy or lactation.**

## COMMON ADVERSE EFFECTS

Abnormal thinking, impaired perception, impaired judgment, loss of motivation, diminished short-term memory, loss of concentration, depersonalization, euphoria, anxiety, panic attacks, paranoia, confusion, hallucinations, depression, dizziness/vertigo, drowsiness, diminished inhibitions; impaired coordination, increased risk of accidents, dry mouth, nausea, vomiting, high or low blood pressure, irregular heartbeat, increased heart rate, and “red” flushing of skin

## DRUG INTERACTIONS

Ritonavir

## PREGNANCY: CATEGORY C

Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks. Most prescription medications are classified in Category C.

## BREAST FEEDING

Potential risk; change in therapy or care plan may be advisable.

Dr. Bob Blake has provided and/or discussed the side effects of Medical Marijuana, and has offered a more comprehensive copy of the side effects of the medicinal use of cannabis.

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PLEASE PRINT YOUR NAME

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PRINT NAME OF PARENT/GUARDIAN  
IF PATIENT IS UNDER AGE 18

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PATIENT SIGNATURE

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DATE

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SIGNATURE OF PARENT OF GUARDIAN  
IF PATIENT IS UNDER AGE 18

Note: Please bring this signed copy of the side effects of medical marijuana to your office visit.

## WHY ARE WE REQUESTING YOUR MEDICAL RECORDS?

Dr. Blake acts as a Consultant (Qualified Medical Marijuana Examiner) only; He is not your primary care provider. In accordance with the rules of the California Medical Board and California Medical Association, your medical records are required for the purpose of validating your qualifying diagnosis(es) to begin or continue the use of Medical Marijuana (Cannabis). You are required to provide Dr. Blake with medical records that confirm your qualifying diagnosis at the time of your initial visit, from one of the Approved Licensed Health Care Providers listed in the table below. If you have already provided Medical Records to Dr. Jimenez, Dr. Blake has your records.

### Approved Licensed Health Care Providers

Physicians (M.D. or D.O.)	Psychiatrist (M.D.)
Licensed Acupuncturist (L.Ac.)	Psychologist (Psy.D. or Ph.D.)
Doctor of Chiropractics (D.C.)	Licensed Clinical Social Worker (LCSW)
Doctor of Naturopathy (N.D.)	Optometrist (O.D.)
Dentist (D.D.S. or D.M.D.)	Other qualified, licensed professional you deem as your primary care provider.
Licensed Marriage and Family Therapist (LMFT)	

If you do not provide proper medical records during your visit you will be required to submit records in support of your qualifying diagnosis within the time frame specified by Dr. Blake at the time of your examination, usually 6 weeks. The records must be on the practitioner's letterhead, a prescription form, or some other form of properly documented medical, psychological or legal report

If you have never seen one of the providers listed above for your condition and Dr. Blake examines you and determines that you indeed suffer from a condition which would qualify you for a trial of Medical marijuana (Qualifying Diagnosis), you will be **REQUIRED** to see the provider **of your choice** from the list of approved licensed providers above, and provide medical records that support and confirm your "qualifying diagnosis" within the time frame specified by Dr. Blake.

PATIENT INITIALS \_\_\_\_\_

# REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

DOB: \_\_\_\_\_ Previous Names Used: \_\_\_\_\_

Driver's License  State ID Card \_\_\_\_\_  Passport# \_\_\_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF PARENT OF GUARDIAN  
IF PATIENT IS UNDER AGE 18**

\_\_\_\_\_  
**PRINT NAME OF PARENT/GUARDIAN  
IF PATIENT IS UNDER AGE 18**

By signing above, I Hereby Authorize (print name and address of practitioner below):

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TO RELEASE INFORMATION TO:**

**Bob E. Blake, M.D.  
28 Monarch Bay Plaza, Suite B  
Dana Point, Ca 92629**

**FAX: 201-301-0104**

I request that copies of my medical records including, but not limited to, the following items be sent:

Problem list/medication list (Summary only)

Hospital Discharge summary

History and Physical Examination

Other \_\_\_\_\_

Note: We do not need your entire medial records, just a summary of the Medical and/or Mental health Problem list and a Medication list (this is usually one to 3 pages).