

MEDICAL MARIJUANA OF SAN DIEGO  
5703 OBERLIN DRIVE, SUITE 203  
SAN DIEGO, CA 92121  
888-215-HERB



MEDICAL MARIJUANA OF ORANGE COUNTY  
28 MONARCH BAY PLAZA, SUITE B  
DANA POINT, CA 92629  
949-388-3525

## MEDICAL MARIJUANA

**New Patient Instructions:** Please fill out all pages of these forms. Page 8 should be completed only if you need to request copies of your medical records. These forms may be filled out in 2 ways:

1. Use the Typewriter Tool in Adobe Acrobat Reader to fill them out, then PRINT the completed forms and sign where required.
2. You may also just print the forms, fill them out by hand, and sign where required.

**PLEASE BE SURE TO BRING THE COMPLETED FORMS WITH YOU TO YOUR APPOINTMENT!**

First Name:	MI:	Last Name:	
CA Drivers License:	State ID Card:		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:		Rev. 2011-06-24
Phone:	Email:		
Street Address1:			
Street Address2:			
City:	State: <input type="checkbox"/> CA	Zip:	

**RENEWAL REMINDER?** May we send a reminder that your recommendation for medical marijuana is about to expire, to the email address listed above, 30 days before your recommendation is due to expire?

- Yes, please send an email reminder.  
 No, do not send an email reminder.

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

\_\_\_\_\_  
DATE

MEDICAL MARIJUANA NEW PATIENT PROBLEM HISTORY

LAST NAME:	FIRST NAME:	MI:
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1. Please list the Condition(s) for which you seek relief with Medical Marijuana AND the YEAR that condition began in the boxes below:


2. **CIRCLE** any of the conditions you listed above for which you have you seen an Approved Health Care Provider (see list below).

3. Are you currently being treated for your condition(s) by one of the "**Approved Health Care Providers**" listed below?  Yes  No

4. When was the last time you saw one of the "**Approved Health Care Providers**" listed below for your condition?

<input type="checkbox"/> 1 month ago or less	<input type="checkbox"/> 3 months ago or less	<input type="checkbox"/> 6 months ago or less	<input type="checkbox"/> 1 yr ago or less
<input type="checkbox"/> 1-3 years ago	<input type="checkbox"/> 3-7 years ago	<input type="checkbox"/> more than 7 years ago	<input type="checkbox"/> Never

5. Do you have medical records with you that support your condition?  Yes  No

6. Can you get medical records\* that support your condition?  Yes  No  
 \*Medical records are generally kept for 7 yrs by doctors and hospitals.

7. Please list any medicines that have been prescribed for your condition(s) and any adverse reactions you may have had to those medicines in the table below. You may continue at the bottom of the page:

Medicine	Adverse Reaction	Did the medicine help?
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat

8. Check any treatments, other than medications, you may have had for this condition and whether of not it helped.

Treatment	Did it help?	Treatment	Did it help?
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
<input type="checkbox"/> Chiropractic care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	<input type="checkbox"/> Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat	<input type="checkbox"/> Chinese herbs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat

9. List any other treatment(s) you may have had?

10. Did it help?  Yes  No  Somewhat

11. Have had surgery for this condition.  Yes  No If yes, how many times?

12. Have you used cannabis for this condition?  Yes  No

13. Did it help?  Yes  No  Somewhat

Additional Information:


**Approved Health Care Providers**

Physicians (M.D. or D.O.) Licensed Acupuncturist (L.Ac.) Doctor of Chiropractics (D.C.) Doctor of Naturopathy (N.D.) Dentist (D.D.S. or D.M.D.) Licensed Marriage and Family Therapist (LMFT)	Podiatrist (D.P.M.) Psychiatrist (M.D.) Psychologist (Psy.D. or Ph.D.) Licensed Clinical Social Worker (LCSW) Optometrist (O.D.) Other qualified, licensed professional:
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**PATIENT INTAKE MMOC / MMSD**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**DRUG ALLERGIES:** Do you have any Drug allergies?  No  Yes: Please list them in the table below.

Drug to which you were allergic:	What was your reaction:
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:

**CURRENT MEDICATION LIST:** Please list all medications you are CURRENTLY taking below.


**PAST MEDICAL HISTORY**

Please place a check mark  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"/> Arthritis <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Osteo/Degenerative <input type="checkbox"/> Psoriatic <input type="checkbox"/> Neck pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Low back pain <input type="checkbox"/> Sciatica <input type="checkbox"/> tailbone 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 or <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 (Kidney stones, Interstitial 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 <input type="checkbox"/> other neurodegenerative disease: _____ <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Chronic Nausea <input type="checkbox"/> Prostate enlargement <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Rheumatic disease: <input type="checkbox"/> Lupus <input type="checkbox"/> Sjogren's <input type="checkbox"/> Reiter's <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:
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**PAST SURGICAL HISTORY:** List any **surgeries** you have had and the approximate year in the boxes below.


**SOCIAL HISTORY:** Marital Status:  Single  Married  Widowed  Divorced  Domestic Partner

Have you ever abused Street Drugs, prescription drugs or alcohol?  Yes  No

If you answered yes, please place a "✓" next to each of the drug(s) you have abused:  alcohol  Heroin  Cocaine

Methamphetamine  Other: \_\_\_\_\_ Are you currently abusing?  Yes  No

Do you smoke tobacco?  Yes  No

Have you smoked tobacco in the past?  Yes  No

Have you ever used cannabis before? (If "NO" you may go on to the next page)  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.

CONTINUED FROM ABOVE:


**STAFF USE ONLY:** BP: \_\_\_\_\_ / \_\_\_\_\_ PULSE: \_\_\_\_\_ Date: \_\_\_\_\_

ACKNOWLEDGMENT AND CONSENT  
MMOC / MMSD

Initials

- \_\_\_\_\_ I voluntarily consent to receive medical and health care services from Bob E. Blake, M.D., A Professional Corporation (APC) and its physicians.
- \_\_\_\_\_ 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 Bob E. Blake, M.D., APC to verify that I have received a recommendation to use medical marijuana to Law Enforcement officials, dispensaries, collectives and coops.
- \_\_\_\_\_ I understand that I must be a California State resident to obtain a physician's recommendation for the use of medical marijuana. 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 by the Food and Drug Administration concerning the safety and effectiveness of marijuana as a drug and I 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 marijuana 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 use medical marijuana, including risks with respect to the effects upon my cardiovascular and pulmonary systems (heart and lungs) and 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 Bob E. Blake, M.D., APC or any of its physicians responsible for any medical or legal ramifications.
- \_\_\_\_\_ I understand that I am not to drive, operate machinery, or engage in hazardous activities, while under the influence of medical marijuana.
- \_\_\_\_\_ Furthermore, I, the undersigned, my heirs, assignees, or anyone acting on my behalf, hold Bob E. Blake, M.D., APC and its physicians, principals, agents, and employees, free of and harmless from any liability resulting from my use of cannabis.
- \_\_\_\_\_ I attest that the information I have submitted to Bob E, Blake, M.D. APC, is correct and any medical history presented to 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 or illegally distributing medical marijuana.
- \_\_\_\_\_ 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 medical marijuana provides substantial relief and improvement in my condition.
- \_\_\_\_\_ I acknowledge that I am not an agent of law enforcement, state or federal government here for the purpose of investigation or entrapment.
- \_\_\_\_\_ I acknowledge that I am not recording any portion of my visit with Bob E. Blake, M.D., APC and its physicians and staff, nor do I possess any audio or video recording equipment. I understand Bob E. Blake, M.D., APC does not approve such action.

\_\_\_\_\_  
**PRINT YOUR NAME ABOVE**

**X**

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

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AT THE OFFICE OF BOB E. BLAKE, M.D., A PROFESSIONAL CORPORATION

How would you like to be contacted for matters such as appointment reminders and other Protected Health Information? Please 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: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

The HIPAA privacy rule gives individuals the right to determine how their Protected Health Information (PHI) is used and to whom it may be disclosed. It is our policy not to disclose any of your PHI to anyone unless we are specifically authorized to do so by you, in writing, with a signed Medical Information Release. We will notify you if we receive a subpoena for any of your PHI. You may then decide whether or not you want to authorize us to release any of your PHI. Without your authorization it will take a Judge's Subpoena or Court Order for us to release any of your PHI. It is essential that we have a way to contact you.

The individual is also provided the right to request confidential communications and communication of PHI be made by alternative means such 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.

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.

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

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

POSSIBLE SIDE EFFECTS OF MEDICAL MARIJUANA  
MMOC / MMSD

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

**CONTRAINDICATIONS:**

Hypersensitivity to tetrahydrocannabinol (THC) or dronabinol (synthetic THC).

**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 (an antiviral agent used to treat patients who are HIV positive or have AIDS)

**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.

The doctor 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.

X \_\_\_\_\_  
PATIENT SIGNATURE DATE

# MEDICAL RECORDS POLICY OF BOB E. BLAKE, M.D., APC

## Q. WHY ARE WE REQUESTING YOUR MEDICAL RECORDS?

A. Because it is required that we do so by the California Medical Board! For your protection we strictly adhere to ALL rules and regulations set forth by the California Medical Board (CMB). We suggest that you visit the following web site for the complete text of the CMB's position statement on Medical Marijuana.

[http://www.medbd.ca.gov/medical\\_marijuana.html](http://www.medbd.ca.gov/medical_marijuana.html)

We have quoted the pertinent section of this document immediately below:

5. A physician who is not the primary treating physician may still recommend medical marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.

Our doctors act as Medical Marijuana Consultants only, NOT as your primary treating physician. Therefore, you are required to provide us with medical records that confirm your qualifying diagnosis, either at the time of your initial visit OR within the timeframe specified by the physician by whom you are seen at our clinic. Usually medical records will be due no later than 3 months after your initial visit.

The medical records that you submit should be from one of the Approved Licensed Health Care Providers listed below.

### Approved Licensed Health Care Providers

Physicians (M.D. or D.O.)  
Licensed Acupuncturist (L.Ac.)  
Doctor of Chiropractics (D.C.)  
Doctor of Naturopathy (N.D.)  
Dentist (D.D.S. or D.M.D.)  
Licensed Marriage and Family Therapist (LMFT)

Psychiatrist (M.D.)  
Psychologist (Psy.D. or Ph.D.)  
Licensed Clinical Social Worker (LCSW)  
Optometrist (O.D.)  
Other qualified, licensed professional you deem as your primary care provider.

## Q. WHAT IF I HAVE NEVER SEEN A DOCTOR FOR MY CONDITION?

A. If you have never seen one of the providers listed above for your condition and upon examining you our doctor determines that you indeed suffer from a condition which would qualify you for a medical marijuana recommendation, you will be given a 3 month temporary recommendation and REQUIRED to see the provider of your choice from the list of approved licensed providers above, from whom we will then be able to obtain records in support of your qualifying condition. Upon receipt of your medical records your recommendation may then be extended to its full length, up a maximum of one year, depending upon your condition.

I have read the medical records policy above.

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

\_\_\_\_\_  
DATE

# REQUEST FOR RELEASE OF MEDICAL RECORDS

Patients Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

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

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

X \_\_\_\_\_

PATIENT SIGNATURE

\_\_\_\_\_

DATE

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

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

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

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

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

## TO RELEASE INFORMATION TO:

Bob E. Blake, M.D. , APC  
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)

Mental health problem list/medication list (Summary only, do not include psychotherapy session notes)

History and Physical Examination

Hospital Discharge summary

Other \_\_\_\_\_

Note: We do not need your entire medical record; **a summary** of the Medical and/or Mental health Problem list and a Medication list will generally suffice.