GreenStar Medical of Florida
Patient Intake Form

General Information

Filling out this form does not guarantee an approval or recommendation for the use of medicinal cannabis.

Full Name	First Name	Middle Name	Last Name	DOB	
Address	Street	City	State	Zip	
Telephone		Phone#			
Email		Can we contact you by email?	☐ Yes ☐ No		
May we text you?	☐ Yes ☐ No	Text #			
Age		Occupation			

Medical Information

Current Medical Condition		
Are you currently under the care of a physician?	☐ Yes ☐ No	If yes, what is the name of your primary care physician?
Physician's Address		
Telephone		
If no, please provide us with the name of the physician or medical facility that you visited for your medical condition(s)		
Did you bring medical records/documentation today?	☐ Yes ☐ No	If yes, what did you bring?
Have you been evaluated for the use of medical marijuana by any other physician in the past?	☐ Yes ☐ No	If yes, please give name of doctor, date seen and condition for which cannabis was approved
Have you been evaluated and denied a Medical Cannabis Recommendation?	☐ Yes ☐ No	If yes, please explain
Are you currently enrolled or attending school?	☐ Yes ☐ No	If yes, please specify ☐ HS ☐ College ☐ Other
Do you have children?	☐ Yes ☐ No	If yes, what are your children's ages?
Female Patients:		
Are you pregnant?	☐ Yes ☐ No	
Are you planning a pregnancy?	☐ Yes ☐ No	

Have you been arrested or charged with a crime in the last 2 years?	☐Yes ☐No
If yes, please specify	

Are you currently on parole/probation?	☐ Yes ☐ No
Are you currently attending or have you attended any drug/substance abuse or rehabilitation program?	☐ Yes ☐ No If yes, then

Name of program?	Date entered	Reason for entering the program?

Have you ever been treated for symptoms of depression, been psychotic, attempted suicide or had any other mental problems?	☐ Yes ☐ No
If yes, explain	

Have you ever been prescribed or taken medication for any of these problems?	☐ Yes ☐ No
If yes, what medications	
If applicable, what is the name of your mental health physician	

Do you currently smoke tobacco?	☐ Yes ☐ No	If yes, how often and how many per day?
Do you currently use marijuana?	☐ Yes ☐ No	If yes, how much do you use per week
Are you taking any medications?	☐ Yes ☐ No	If yes, name the medication(s) and dosages below
Do you have any allergies to medicine?	☐ Yes ☐ No	If yes, please list medicine below
Have you ever been hospitalized?	☐ Yes ☐ No	If yes, give dates and details below

Dates	Details

Have you ever had surgery?	☐ Yes ☐ No	If yes, give dates and details below

Dates	Details

Please indicate if you or your immediate family members have had any following problems:			
☐	Asthma	☐	Heart Disease
☐	High Blood Pressure	☐	Stroke
☐	Diabetes	☐	Tuberculosis
☐	Hepatitis Substance Abuse	☐	Alcoholism
☐	Alcoholism	☐	Cancer Kidney Disease
☐	Sinusitis		
Please indicate if you have had any of the following symptoms consistently:			
☐	Sleeplessness	☐	Skin Rashes
☐	Chest Pain	☐	Palpitations
☐	Constipation	☐	Headaches
☐	Stomach Pain	☐	Coughing
☐	Depression	☐	Heartburn
☐	Vomiting	☐	Seizures
☐	Nausea	☐	Diarrhea
☐	Anxiety	☐	Rectal Pain
☐	Chronic Pain	☐	Fever
☐	Eye Problems	☐	Blood in Bowels
☐	Difficulty Swallowing		
Describe any other health problems that occur frequently with you or in your family			

Signature

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal for a patient to film or record in this office with video camera, cell phone or any other recording device whether still image, video or audio. This is a direct violation of HIPAA regulations and Patient/Doctor confidentiality.

I am aware that my approval or recommendation may be revoked at any time if I have perjured or misrepresented myself or my condition.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient Signature _____ Physicians Initials _____