CMC – CANNABIS USAGE WORKSHEET AND PHYSICAN CERTIFICATION

SOCIAL SECURITY #_____ ***PATIENT LEGAL NAME (AS IT APPEARS ON YOUR DRIVERS LICENSE OR ID)***

LAST NAME_____**FIRST NAME**_____

DATE OF BIRTH_____**AGE**_____ ARE YOU CONSIDERED HOMEBOUND, example: TOO ILL TO LEAVE YOUR HOME? YES ◯ or NO ◯

CIGARETTE SMOKER ◯ YES ◯ NO, YOUR MEDICAL RECORDS ARE: __ON FILE ☐ IN HAND ☐ AT HOME ☐ NONE ☐

PATIENTS HEALTH HISTORY - YOU MUST CIRCLE CONDITION(S) THAT APPLY TO YOU									
CANCER ☐	GLAUCOMA ☐	HIV or AIDS POSITIVE ☐	CACHEXIA ☐	SEVERE NAUSEA ☐	SEIZURES ☐	PERSISTENT MUSCLE SPASMS ☐	SEVERE PAIN ☐	PTSD ☐	AUTISM ☐

Please indicate how Times (X) you medicate with Cannabis per Day (D) or Week (W) or Month (M)

EXAMPLE: Edibles, Topicals, Tinctures, Smoking, Vaping, Juicing 2 Times (X) Week or 4 Times (X) a Day ETC.

Edibles____**(X)**_____Topicals____**(X)**_____Tinctures____**(X)**_____Smoke ____(**X)**____Vape___(**X)**____ Juicing _____(**X)**____

I AM CURRENTLY IN TREATMENT AND/OR HAVE BEEN DIAGNOSED WITH ONE OF THE ABOVE CIRCLED DEBILITAING MEDICAL CONDITIONS

PATIENT SIGNATURE _____**DATE:** _____

DO NOT WRITE BELOW THIS LINE------For CMC DOCTORS PURPOSES ONLY---DR. RECOMMENDATION/MED. CANNABIS Plan

Recommended: CBD _____mg to _____mg per dose THC _____mg to _____mg per dose

Chronic care/Long Acting: Edible _____Oral _____Topical _____Times per Day _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Number of Plants _____Oz_____ 6B ETIOLOGY:_____

_____

STANDARD PLANT COUNT _____EXTENDED PLANT COUNT_____RETURNING CMC PATIENT YES/NO PRIOR PLANT COUNT _____/_____

B/P_____/_____PULSE_____ OCCUPATION_____

_____ _____ _____

CBD CONSULT ***PHYSICIANS SIGNATURE*** ***DATE***