PMC Medical Group, LLC

Therapeutic Cannabis

Marijuana History Form

Name:_____ DOB:_____

Are you currently using marijuana? YES____ NO____

Current Dosage: (example: 2-3 puffs three times a day, or ¼ ounce per week)

_____

Current Delivery System: (pipe, joint, vaporizer, tincture, etc.)

_____

High/Low Quality Strain:

_____

Age at first use of marijuana _____

Previous marijuana use:

Dose: _____

Delivery System: _____

Other comments: _____

Have you had any adverse effects from marijuana use? YES___ NO____ If Yes, Please explain:

_____

_____

Have you ever had a reaction from marijuana use? YES____ NO____

Please explain: (anxiety, depression, paranoia, etc.)

_____

_____

Other pertinent history: _____

_____

_____

Patient Signature: _____ Date: _____