LONG ISLAND COMPASSIONATE MEDICAL CENTER

Dr. Jahanzeb Chaudhry

PATIENT INFO SHEET:

NAME: _____ DOB:_____

PHONE:_____

ADDRESS:_____ MALE __ FEMALE __

CITY: _____ STATE: _____ ZIP: _____

SS#:_____ DRIVERS LICENSE #:_____

EMAIL ADDRESS:_____ MAY WE EMAIL YOU IN THE FUTURE? YES NO

- How did you hear about us? _____
- Are you currently working? Yes / No (**if yes)** What is your job? _____
- Are you: Full Time / Part Time / Unemployed / Disabled / Retired / Homemaker / Self Employed
- Marital Status: Married / Divorced / Separated / Widowed / Never Married / Other _____
- Do you have children? Yes / No (**if yes,** what are their ages) _____
- **(If female)** Are you currently pregnant? Yes/No
- **(If female)** Are you planning on getting pregnant? Yes / No
- (**If female**) Are you currently breast feeding? Yes / No
- Have you been arrested or charged with a crime in the past two years? Yes / No (**If yes**, please describe)
  _____
- Have you been evaluated for medical marijuana use by another physician in the past? Yes / No
  (**If yes,** please give name of practice, doctor, date seen and condition for evaluation)
  _____
- Have you been denied a recommendation for medical marijuana use by another MD in the past?
  Yes / No(**If yes,** please explain) _____
- Are you currently attending, or have you attended any substance abuse or rehabilitation program?
  Yes/No (**If yes,** please provide details) _____
- Do you ever have thoughts of suicide or have you ever attempted suicide? Yes / No
  (**If yes,** please provide details)_____-_____

PRIMARY CARE PHYSICIAN:

NAME: _____ PHONE: _____

ADDRESS: _____ FAX: _____

CITY: _____ STATE: _____ ZIP:_____

SPECIALISTS: (IE: ONCOLOGISTS, PAIN MANAGEMENT, AND NEUROLOGIST ECT.) _____

- Did you bring any medical records with you today? Yes / No
- Have you talked to your primary care physician about medical marijuana? Yes / No

FOR OFFICE USE ONLY: ENTERED IN EMR? YES NO INITIAL:

CURRENT MEDICAL REVIEW:

1. Do you currently use tobacco? Yes / No (**if yes)** How often? _____

2. Do you currently use marijuana? Yes / No (**if yes)** How often and what methods? _____

_____

3. Do you currently drink alcohol? Yes / No (**if yes)** How often? _____

4. Do you currently use cocaine, methamphetamine, opiates, heroin or other street drugs? Yes / No

(**If yes, explain**) _____

Please circle any of the following problems **anyone in your immediate family** has:
Asthma / Stroke / High Blood Pressure / Cancer / Diabetes / Alcoholism / Hepatitis
Tuberculosis / Substance Abuse / Kidney Disease / Heart Disease / Sinusitis / Other _____

PLEASE LIST PAST SURGERIES AND DATES: (PLEASE LIST ANY MEDICAL CONDITIONS THAT HAVE BEEN EVALUATED BY A PHYSICIAN OR HOSPITAL OR CURRENTLY BEING TREATED FOR)_____

_____
_____
_____

PLEASE LIST ALL CURRENT MEDICATIONS: (PLEASE LIST MEDICATIONS YOU ARE TAKING ON A DAILY BASIS OR OCCASIONAL BASIS. PLEASE ALSO INCLUDE OVER THE COUNTER MEDICATION, DOSAGES AND FREQUENCY**.)**_____

_____
_____
_____

ALLERGIES: (PLEASE LIST ALL ALLERGIES TO MEDICATIONS; PLEASE ALSO LIST SEVERITY AND REACTION.)

_____

I HERBY ATTEST THAT ALL INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE _____ DATE:_____

MEDICAL HISTORY:

PRIMARY CONDITION IN WHICH YOU ARE REQUESTING MEDICAL MARIJUANA (MM) (CIRCLE ALL THAT APPLY)

AIDS/ HIV

INFLAMMATORY BOWEL DISEASE (IBS)

PARKINSONS

CANCER

ACUTE PAIN

MULTIPLE SCLEROSIS (MS)

NEUROPATHY

SPINAL CORD INJURY WITH SPASTICIT

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

EPILEPSY

HUNTINGTONS

CHRONIC PAIN

POST TRUAMATIC STRESS DISORDER (PTSD)

- PLEASE LIST ALL TREATMENTS FOR THIS PROBLEM:_____

_____

- DO YOU HAVE LABS, XRAYS, EMG'S,ECT..:_____

PLEASE LIST ALL ASSOCIATED SYMPTOMS AND DATE SYMPTOMS STARTED AND DATE DIAGNOSED BY PRIMARY DOCTOR.

CACHEXIA OR WASTING SYNDROME

CHRONIC PAIN

NAUSEA

SEVERE OR PERSISTANT MUSCLE SPASMS

SEIZURES

PLEASE EXPLAIN IN DETAIL :(HOW LONG YOU HAVE HAD SYMPTOMS, FREQUENCY AND INTENSITIY OF SYMPTOMS)

_____

PLEASE CIRCLE ANY OTHER SYMPTOMS WHICH PERTAIN TO YOU AND YOUR DIAGNOSIS. (ANYTHING YOU CIRCLE MUST HAVE SUPPORTING DOCUMENTATION FROM YOUR DOCTOR)

ANXIETY	ACID REFLUX	WEIGHT LOSS
DIZZINESS	NUMBNESS OR TINGLING LIMBS	URINARY PROBLEMS
HEADACHES	INSOMNIA	
LOSS OF APPITITE	DEPRESSION	
MUSCLE SPAMS	MUSCLE/JOINT/ BONE PAIN	
NAUSEA	VOMITING	

MEDICAL HISTORY CONT':

ANY OTHER MEDICAL HISTORY INFORMATION THAT YOU FEEL NECESSARY TO LET US KNOW PLEASE USE THIS SPACE TO DO SO: ALSO PLEASE INCLUED THERAPIES AND TREATMENTS YOU HAVE TRIED AND FAILED.

_____
_____
_____
_____

MEDICAL MARIJUANA RISKS AND BENEFITS

PLEASE INITIAL EACH SECTION AFTER YOU HAVE READ IT*

Medical marijuana is a pharmaceutical that can help with the side effects of many medical conditions, including cancer, HIV/AIDs, multiple sclerosis, glaucoma. It can also be used to treat the debilitating symptoms of many medical conditions such as chronic pain. Like all medicines, medical marijuana may cause certain side effects.

Legalization of marijuana for medical use or adult recreational use in a growing number of states may affect these views. Read more about marijuana as medicine in *DrugFacts: Is Marijuana Medicine?* at www.drugabuse.gov/publications/drugfacts/marijuana-medicine.

Compounds in marijuana can relieve pain, combat nausea and stimulate appetite. It had been shown to help reduce nausea and vomiting and stimulate appetite during chemotherapy. It has been suggested to be beneficial in the treatment of patients with AIDS, ALS, Crohn's disease, Parkinson's disease, glaucoma, Hepatitis C, multiple sclerosis and may reduce pain in certain chronic medical conditions. Its benefits have also been suggested in other chronic diseases including arthritis, PTSD, and Alzheimer's.

Medical Marijuana, however, has also been shown to have short and long-term side effects. There are known and unknown side effects and certain risks in the use of medical marijuana.

_____ Cannabis short-term side effects

Short-term Cannabis side effects include:

Most common:

- Anxiety
- Paranoia

Individuals may also have:

- memory and learning problems
- distorted perception
- panic
- sensory distortion
- difficulty thinking
- delusions
- difficulty solving problems.
- anxiety
- poor coordination of movement
- lowered reaction time
- increased heartbeat
- hallucinations
- depersonalization

The more severe side effects usually occur in inexperienced users after large doses and disappear within hours. As many as 17% of regular marijuana smokers report experiencing at least one of these symptoms

_____ Cannabis long-term side effects

Long term side effects of regular Cannabis use include:

- lung disease
- chronic cough
- mucus
- nasal congestion
- lack of motivation
- decrease in sexual desire
- weight gain
- increased risk of cancer including testicular, lung and bladder cancer
- psychosis or schizophrenia
- cognitive impairment

- chronic bronchitis
- personality and mood changes
- reduced resistance to common illnesses (colds, bronchitis, etc.)
- potential suppression of the immune system
- reduction of male sex hormones
- reduced sexual capacity
- study difficulties: reduced ability to learn and retain information
- apathy, drowsiness, lack of motivation
- inability

Psychosis

Cannabis use may be linked to the development of psychotic symptoms. Heavy pot smoking as a teenager or young adult raises the risk of having psychotic symptoms later in life.

Heart attacks

Cannabis users appear to have a shorter life expectancy after suffering a heart attack. Cannabis triggers a spike in resting heart rate, as well as increase in blood pressure.

Erectile dysfunction

Regular users may notice difficulty in maintaining an erection. A short time after stopping regular use, erectile function can return to normal.

Pregnancy

Women who smoke Cannabis during pregnancy may impair their baby's growth and development in the womb. Regular use of cannabis throughout pregnancy may be associated with a small decrease in birth weight.

Cannabis withdrawal

Repeated Cannabis use may induce a withdrawal syndrome, characterized irritability, anxiety, craving, decreased quality and quantity of sleep, and decreased food intake.

_____ Fertility

The likelihood of a good outcome of fertility treatment is reduced if either the man or the woman uses Cannabis. Couples should not use Cannabis for at least six months before starting fertility treatment.

Effects on driving

Cannabis usage has been shown to negatively affect the ability to drive. Drivers who consume cannabis within three hours of driving are nearly twice as likely to cause a vehicle collision as those who are not under the influence of drugs or alcohol. The effects of cannabis on laboratory-based tasks show clear impairment with respect to tracking ability, attention, and other tasks depending on the dose administered.

_____ Alcohol

Using marijuana while under the influence of alcohol is not recommended under any circumstance. Additional side effects may become present when using both alcohol and marijuana. Cannabis should be treated as an open container of alcohol and may subject one to arrest.

PATIENT RELEASE AND ACKNOWLEDGEMENTS:

(PLEASE READ FULLY AND INITIAL EACH SECTION)

_____ 1. I ACKNOWLEDGE THAT LONG ISLAND COMPASSIONATE MEDICAL CENTER (LICMC) HAS INFORMED ME THAT MM IS AN ALTERNATIVE TO THE RECOMMENDED TREATMENT AND HAS INFORMED ME OF THE RISKS AND BENEFITS OF SHORT AND LONG TERMS USE OF MM.

_____ 2. THE PURPOSE OF MY VISIT TO LICMC IS FOR A CONSULTATION WITH THE PHYSICIAN AND THE EVALUATION OF MY MEDICAL HISTORY AND MEDICAL RECORDS. THIS CONSULTATION , WILL ALLOW THE PHYSICIAN TO DETERMINE IF I QUALIFY FOR A MM CARD TO BE ISSUED BY THE NEW YORK DEPARTMENT OF HEALTH FOR THE USE OF MEDICAL MARIJUANA PURSUANT TO THE NEW YORK STATE LAWS AND REGULATIONS.

_____ 3. I UNDERSTAND FULLY THAT THIS APPOINTMENT IS FOR EVALUATION PURPOSE ONLY AND I MAY NOT BE CERTIFIED FOR MM IF IT IS NOT DEEMED MEDICALLY NECESSARY IN THE DOCTORS PROFESSIONAL OPINION.

_____4. UNDER NO CIRCUMSTANCES WILL ANY PAYMENTS FOR APPOINTMENTS BE REFUNDED. AN OFFICE VISIT PAYMENT IS NOT A GUARANTEE YOU WILL RECEIVE A CERTIFICATION.

_____5. I UNDERSTAND THAT MM MUST BE KEPT IN IT'S ORIGINAL PACKAGING AND MAY NOT BE CONSUMED IN A PUBLIC PLACE.

_____6. I HAVE BEEN ADVISED THAT THE USE OF MEDICAL MARIJUANA MAY AFFECT MY COORDINATION, MOTOR SKILLS AND COGNITION IN WAYS THAT COULD IMPAIR MY ABILITY TO DRIVE AND AGREE NOT TO OPERATE HEAVY MACHINERY, DRIVE OR ENGAGE IN POTENTIALLY HAZARDOUS ACTIVITIES.

_____ 7. I UNDERSTAND THAT USING MM WHILE UNDER THE INFLUENCE OF ALCOHOL IS NOT RECOMMENDED UNDER ANY CIRCUMSTANCE. I SHALL UNDER NO CIRCUMSTANCE DRIVE A CARE OR OPERATE HEAVY MACHINERY UNDER THE INFLUENCE OF MM. I UNDERSTANT THAT IF I AM STOPPED BY A POLICE OFFICER, I CAN BE ARRESTED FOR THE OFFENSE OF DRIVING UNDER THE INFFLUENCE (DUI). MEDICAL MARIJUANA WILL BE TREATED AS AN OPEN CONATAINER OF ALCOHOL AND WILL NOT BE WITHIN REACH OF A CARS INTERIOR.

_____8.I UNDERSTAND THAT SIDE EFFECTS MAY OCCUR WHILE I AM TAKING MEDICAL MARIJUANA. SIDE EFFECTS OF MEDICAL MARIJUANA CAN INCLUDE BUT ARE NOT LIMITED TO: EUPHORIA, DIFFICULTY IN COMPLETING COMPLEX TASKS, LOW BLOOD PRESSURE, SEDATION, DYSPHORIA, ALTERATIONS IN THE PERCEPTION OF TIME AND SPACE, DIZZINESS, ANXIETY, CONFUSION, IMPAIRMENT TO SHORT TERM MEMORY, INABILITY TO CONCENTRATE, SUPPRESSION OF THE BODY'S IMMUNE SYSTEM, INCREASED TALKATIVENESS, IMPAIRMENT OF

MOTOR SKILLS, DELAYED REACTION TIME, LOSS OF PHYSICAL COORDINATION, PARANOIA PSYCHOTIC SYMPTOMS AND OVEREATING.

_____9. I AGREE TO TELL THE ATTENDING PHYSICIAN IF I HAVE EVER HAD SYMPTOMS OF DEPRESSION, BEEN PSYCHOTIC, ATTEMPTED SUICIDE OR HAD ANY OTHER MENTAL PROBLEMS. I ALSO AGREE TO TELL THE ATTENDING PHYSICIAN IF I HAVE EVER BEEN PRESCRIBED OR TAKEN MEDICINE FOR ANY OF THE CONDITIONS STATED ABOVE. FURTHERMORE, I UNDERSTAND THAT THE ATTENDING PHYSICIAN DOES NOT SUGGEST NOR CONDONE THAT I CEASE TREATMENT AND OR MEDICATION THAT STABILIZE MY MENTAL OR PHYSICAL CONDITION.

_____10.I UNDERSTAND THERE ARE FEW KNOWN INTERACTIONS BETWEEN MARIJUANA AND MEDICATIONS OTHER THAN HERBS. HOWEVER, VERY FEW INTERACTIONS BETWEEN HERBS AND MEDICATIONS HAVE BEEN STUDIED. I AGREE TO TELL MY ATTENDING PHYSICIAN IF I AM USING ANY HERBS, SUPPLEMENTS OR OTHER MEDICATIONS.

_____11.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.

_____12.MEDICAL MARIJUANA IS NOT REGULATED BY THE USFDA AND THEREFORE MAY CONTAIN UNKNOWN QUANTITIES OF ACTIVE INGREDIENTS, IMPURITIES AND OR CONTAMINANTS.

_____13.I UNDERSTAND MARIJUANA VARIES IN POTENCY. THE EFFECTS OF MARIJUANA CAN ALSO VARY WITH THE DELIVERY SYSTEM. ESTIMATING THE PROPER MARIJUANA DOSAGE IS VERY IMPORTANT. SYMPTOMS OF MARIJUANA OVERDOSE INCLUDE, BUT ARE NOT LIMITED TO NAUSEA, VOMITING, HACKING COUGH, DISTURBANCES TO HEART RHYTHMS, NUMBNESS IN THE LIMBS, ANXIETY ATTACKS AND INCAPACITATION.

_____14.IF I START TAKING MEDICAL MARIJUANA, I AGREE TO TELL MY ATTENDING PHYSICIAN IF I: START TO FEEL SAD OR HAVE CRYING SPELLS, LOSE INTEREST IN MY NORMAL ACTIVITIES, HAVE CHANGES IN MY NORMAL SLEEPING PATTERNS, BECOME MORE IRRITABLE THAN USUAL, LOSE MY APPETITE, BECOME UNUSUALLY TIRED, WITHDRAW FROM FAMILY AND FRIENDS, OR ANY OTHER SIDE EFFECT THAT IS NOT TO YOUR LIKING.

_____ 15.I AGREE THAT IF I ELECT TO USE MM I WILL USE IT STRICTLY FOR THE TREATMENT OF MY AUTHORIZED MEDICAL CONDITION AND WILL BE AT MY SOLE DISCRETION. IF I ELECT TO USE MM, I HOLD LICMC STAFF AND AGENTS FREE OF ANY RESPONSIBILITY FROM ANY ADVERSE REACTIONS OR HARM RESULTING TO ME OR OTHERS AS A RESULT OF MY USE. I FURTHER ACKNOWLEDGE THAT THE NYS DEPARTMENT OF HEALTH ISSUED MM CARD IS NOT A PRESCRIPTION AND USE IS MY VOLUNTARY ACT.

_____16.I ACKNOWLEDGE I AM NOT AN AGENT OF LAW ENFORCEMENT FOR THE LOCAL, STATE OR FEDERAL GOVERNMENT AND AM NOTHERE FOR THE PURPOSE OF INVESTIGATION OR ENTRAPMENT. I ACKNOWLEDGE I AM NOT A MEMBER OF THE MEDIA OR PRESS AND THAT ALL COMMUNICATION IS STRICLY CONFIDENTIAL. I ACKNOWLEDGE I AM NOT RECORDING ANY

PORTION OF MY VISIT, NOR DO I POSSESS AND RECORDING DEVICES. I UNDERSTAND LICMC DOES NOT APPROVE SUCH ACTION.

_____ 17. I HERBY AUTHORIZE LICMC TO VERIFY MY PATIENT STATUS TO RECOGNIZED LEGAL AUTHORITIES SHOULD I BE DETAINED RELATING TO POSESSION OR USE OF MM. NOT MORE THEN PATIENT STATUS WILL BE DISCUSSED AND NO MEDICAL INFROMATION WILL BE RELASED UNLESS PROPER HIPAA PAPER WORK IS SUBMITTED WITH PATIENTS AUTHORITY AND SIGNATURE.

_____ 18. (FEMALES ONLY) IF I AM OF CHILD BEARING AGE AND BECOME PREGNANT I WILL DISCONTINUE USE IMMEDIATLEY, AS CONTINUED USE MAY BE DETRIMENTAL TO THE FETUS.

_____ 19. I UNDERSTAND THAT IF I AM GIVEN A REGISTRATION NUMBER BY THE PHYSICIAN, I THEN WILL HAVE TO SELF REGISTER ONLINE OR BY PAPER FORM WITH THE D.O.H IN ORDER TO OBTAIN A MM CARD. ALSO ANY FEES THAT OCCUR WITH ONLINE REGISTRATION HAVE NO BEARING ON PAYMENTS MADE IN THIS OFFICE. I ALSO UNDERSTAND THERE CAN BE FEES ASSOCIATED WITH LOST AND REISSUING CARDS.

_____20.THE PHYSICIAN, STAFF AND REPRESENTATIVES OF LICMC ARE ADDRESSING SPECIFIC ASPECTS OF MY MEDICAL CARE AND, UNLESS OTHERWISE STATED, ARE IN NO WAY ESTABLISHING THEMSELVES AS MY PRIMARY CARE PHYSICIAN/PROVIDER. FURTHERMORE, THE UNDERSIGNED, MY HEIRS, ASSIGNS, OR ANYONE ELSE ACTING ON BEHALF, HOLD THE PHYSICIAN AND HIS/HER PRINCIPALS, AGENTS AND EMPLOYEES, FREE OF AND HARMLESS FROM ANY RESPONSIBILITY FOR ANY HARM RESULTING TO ME AND/OR OTHER INDIVIDUALS AS A RESULT OF MY MEDICAL MARIJUANA USE.

I HAVE READ EACH SECTION FULLY AND FULLY UNDERSTAND WHAT I AM SIGNING. ANY QUESTIONS I HAVE I WILL BRING FOURTH TO THE DOCTOR.

SIGNATURE: _____ DATE: _____

RELEASE OF LIABILITY:

1. I attest that the information on this form is correct and any medical history presented or discussed with the doctor is all 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 marijuana. Solely for verification purposes, I

authorize Long Island Compassionate Medical Center (LICMC)to converse of my medical condition.

2. I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief and improvement in my condition.

3. It should be made clear that the physician, staff and representatives of this practice are not providing medical marijuana, nor are they encouraging any illegal activity in my obtaining medical marijuana

*** I, _____ CONFIRM THAT THE INFORMATION PROVIDED BY ME OR MY**
(PRINT NAME)

AUTHORIZED REPRESENITIVE REGUARDING ANY OF MY MEDICAL INFORMATION DOCUMENT HERE TODAY IS ACCURATE AND ANY FALSIFICATION OF INFORMATION IS SUBJECT TO DENIAL OR TERMINATION OF CERTIFICATION OF MEDICINAL MARIJUANA.

*I UNDERSTAND THAT THE **NON REFUNDABLE** FEES FOR MM OFFICE VISITS ARE AS FOLLOWS:

- INITIAL CONSULTATION & CERTIFICATION VISIT- $200

-1 MONTH CERTIFICATION -$100

- 3 MONTH CERTIFICATION -$250 (SAVE $50) +

-6 MONTH CERTIFICATION-$ 400 (SAVE $200)

SIGNATURE: _____ DATE: _____

WITNESS SSIGNATURE:_____ DATE:_____