Cannabis Consultants
OF DAYTON

(937) 293-6312

3080 Ackerman Blvd.
Dayton, OH 45429

Personal Medical History

Name____
_

Date of Birth____________________________________

Qualifying condition(s) and physician who diagnosed the condition:

____
_

____
_

When did the problem(s) begin____

What treatments have you received for the problem(s)____________________________________

____

Current Medications - name, dose, how often taken

____

____

____

____
_

Allergies____
_

____

Past
Surgeries____

____

Do you smoke___________________________ Do you drink
alcohol___________________

Drug or alcohol
problems____

Do you have difficulty with any of the symptoms listed below, either now or in the past?
Mark as appropriate.

Vision problems ___ Require glasses___

Hearing problems ___ Ear pain___

Hay fever, sinus problems___

Hoarseness, Difficulty swallowing___

Mouth, throat, tongue ulcers___

Asthma, wheezing___

Shortness of breath___

Chronic cough, cough up blood___

Diabetes___

Past heart attack___

Chest pain with exertion___

High blood pressure___

Irregular Heartbeat / Palpitations___

Tuberculosis___

Herpes / VD / HIV___

Backache, joint pain___

Numbness, tingling___

Swollen or Tender Glands___

Abdominal pain, nausea, vomiting___

Stomach ulcers___

Hepatitis / Jaundice___

Urinary frequency, urgency, pain___

Blood in urine___

Kidney stones___

Bladder control difficulties___

Rectal Bleeding___

Blood in Stool___

Change in bowel habits___

Diarrhea / Constipation___

Poor appetite___

Excessive fatigue or nervousness___

Anxiety___

Depression___

Difficulty Sleeping___

Convulsions / Seizures___

Cancer___

Excessive bleeding, easy bruising___

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ________________________
Signature Date

____ ________________________
Signature Date