DR. NAMITA K. THAPAR-DUA

INTAKE FORM FOR MEDICAL CANNABIS

PATIENT INFORMATION

Last Name _____ First Name _____

Street _____City_____State_____ Zip Code _____

Home Phone# _____ Cell Phone# _____

Email _____ MMCC ID # _____

Birthdate (mm/dd/yyyy) _____ Gender: Male ☐ Female ☐ Other ☐

Qualifying Conditions/Symptoms _____

_____

What have you used to treat these symptoms in the past?

_____

_____

What are your treatment goals from this visit today?

_____

_____

PHYSICIAN CONTACT INFORMATION

Name of Primary Physician _____ Primary Physician Phone# _____

Primary Physician Address_____

Name of Specialist (If applicable) _____ Specialist Phone# _____

MEDICAL INFORMATION

Please check if YOU had any of the following conditions and ***write on the line who in your family has***.

_____ Schizophrenia, Bipolar Disorder or Severe Depression _____

_____ Heart Disease, Chest Pain, High Blood Pressure, Angina or Irregular Heartbeat _____

_____ History of a Stroke _____

_____ Chronic Obstructive Pulmonary Disease (COPD) or Chronic Bronchitis _____

_____ An Immune Disorder or Medical treatment that compromises immune function _____

_____ Taking any medication, such as Blood Thinners? _____

20528 Boland Farm Road Suite 215, Germantown, Maryland 20876

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REFERRED BY

How did you hear about us? ☐ MMCC ☐ Internet ☐ Patient Referral ☐ Other _____

CANNABIS USE HISTORY (IF APPLICABLE)

Have you used Cannabis in the past? ☐ Yes ☐ No If Yes: ☐ Medicinal ☐ Recreational

What do you prefer? ☐ Sativa Strain ☐ Indica Strain ☐ Hybrid ☐ Unsure

What type of Medical products do you prefer:

☐ High THC ☐ Low THC ☐ CBD Dominant ☐ 1:1 ration of Topicals ☐ Other

What type of product do you prefer:

☐ Inhale ☐ Inhaled-Vaporized ☐ Edibles ☐ Topicals ☐ Oils ☐ Concentrates ☐ Other

Dr. Namita Thapar-Dua is not liable for any harm resulting to me and/or other individuals as a result of my medical cannabis use. Possible side effects of medical cannabis can include but are not limited to: increased heart rate, euphoria, dysphoria, confusion, low blood pressure, dizziness, sedation, inability to concentrate, anxiety, overeating, impairment of short term memory, and impairment of motor skills. By purchasing medical cannabis, I agree to remain in compliance with the regulations set forth by the Maryland Medical Cannabis Commission. Any violation with result in immediate cancellation of certification.

Print Name _____

Signature _____ Date _____

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