OMNI MEDICAL SERVICES

PATIENT FOLLOW-UP FORM

Name: _____

Primary Phone: _____

Email Address: _____

Date of Birth: _____ **Weight:** _____ **Gender:** **M** **F**

Address: _____

_____

City: _____ **County:** _____ **Zip:** _____

Has there been a change in your address since your last visit? **YES** **NO**

Patient Number: **P** _____

Are you pregnant, think you may be or actively trying to become pregnant? **YES** **NO** **N/A**

When was the first day of your last period? _____ **N/A**

List of current symptoms:	From 1-10, how severe is it?

Has there been any change in your chief complaint for cannabis treatment since your last visit?

NO **YES** If YES, please explain: _____

Has there been any change in alcohol, cigarette smoking, or illicit drug use since your last visit?

NO **YES** If YES, please explain: _____

Have you been hospitalized since your last visit?

NO **YES** If YES, please explain: _____

Have there been any changes in your health status since your last visit?

NO YES If YES, please explain: _____

Have you experienced any adverse reactions to cannabis?

NO YES If YES, please explain: _____

Did you discontinue the use of cannabis at any time?

NO YES If YES, please explain: _____

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Date of treatment plan: _____ Date of last encounter:_____

Any change in drug order since the last treatment plan? ☐ No ☐ Yes

_____

_____

Any change in the goal(s)of treatment or monitoring of treatment plan? ☐ No ☐ Yes

_____

_____

Planned follow-up date: _____

Patient's condition: ☐ Very much improved ☐ Much improved ☐ Minimally improved
☐ No change ☐ Minimally worse ☐ Much worse
☐ Very much worse

Doctor's signature: _____