OMNI MEDICAL SERVICES

MEDICAL HISTORY AND CURRENT MEDICAL CONDITION

FOR USE IN ASSESSMENT OF PATIENT'S MEDICAL HISTORY AND CURRENT MEDICAL CONDITION(S)

Name: _____ **Age:** _____

Primary Phone: _____ **Social Security #:** _____

Email Address: _____

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

Patient Number*: **P** _____(*DOCTOR WILL ENTER ONCE REGISTERED)

Preferred Form of Ingestion: **Capsules** **Vaporization** **Tinctures** **Aerosol Spray**

Address 1: _____

Address 2: _____

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

Legal Representative 1: _____

Legal Representative 2: _____

Patient's Occupation: _____ **Are you a Military Veteran?** **YES** **NO**

Primary Care Physician: _____ **Phone:** _____

Do you want us to notify your Primary Care Physician? **YES** **NO**

Do you want to receive texts for follow up visits or recertification? **YES** **NO**

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

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

What is your major health complaint? _____

When was your last physical? _____

List of Allergies: _____

List of Medications Currently Taking:

_____

List of Surgeries/Procedures and Their MM/YY:

_____

How did you hear about us? (Please circle)

www.MMJiq.com www.OmniDoctors.com Social Media (Facebook, Google, YouTube, etc)

Newspaper/Magazine Radio Event/Promo Referral:_____

Other:_____

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CURRENT MEDICAL CONDITION(S)

Please Circle Appropriate Response(s):

NO	YES	Are you disabled due to your medical conditions or treatments at this time?
NO	YES	Are you experiencing side effects as a result of drugs, medications, or treatment?
NO	YES	Are you experiencing severe, chronic pain as a result of your condition?
NO	YES	Are you experiencing nausea as a result of your condition?
NO	YES	Are you experiencing severe and persistent muscle spasms as a result of your condition?
NO	YES	Are you experiencing seizures?
NO	YES	Has the severe pain you are experiencing lasted longer than three months?
NO	YES	Has the nausea you are experiencing lasted longer than three months?
NO	YES	Has the severe & chronic muscle spasms you experience lasted longer than 90 days?
NO	YES	Are you experiencing loss of appetite as a result of treatment?
NO	YES	Do you take any vitamins or homeopathic remedies/treatments?
NO	YES	Do you have Cancer?
NO	YES	Do you have Glaucoma?
NO	YES	Do you have Alzheimer's disease?
NO	YES	Do you have Positive Status HIV?
NO	YES	Do you have AIDS or an AIDS defining illness?
NO	YES	Do you have Hepatitis C?
NO	YES	Do you have Amyotrophic Lateral Sclerosis? (ALS - Lou Gehrig's Disease)
NO	YES	Do you have Crohn's Disease?
NO	YES	Do you have Nail Patella?
NO	YES	Do you have Epilepsy?
NO	YES	Do you have Multiple Sclerosis?
NO	YES	Do you have Diabetes?
NO	YES	Do you have Tourette's Syndrome?
NO	YES	Do you have Heart Disease?
NO	YES	Do you have Kidney Disease?
NO	YES	Do you have Fibromyalgia?
NO	YES	Do you have GI Disorders?
NO	YES	Do you have Glioma?
NO	YES	Do you have Hypertension?
NO	YES	Do you have Anorexia?
NO	YES	Do you have Anxiety Attacks?
NO	YES	Do you have Arthritis?
NO	YES	Do you have Asthma?
NO	YES	Do you have Constipation?
NO	YES	Do you have Insomnia?
NO	YES	Do you have Intestinal Cramps?
NO	YES	Do you have Intractable Hiccups?
NO	YES	Do you have Meniere's Syndrome?
NO	YES	Do you have Migraine Headaches?
NO	YES	Do you have Neuralgia?
NO	YES	Do you have Neurodermitis?
NO	YES	Do you have Night Sweats?
NO	YES	Do you have Overly Painful Premenstrual Syndrome?
NO	YES	Do you have Respiratory Diseases?
NO	YES	Do you require Stress Reduction?
NO	YES	Have you ever suffered a Stroke?
NO	YES	Are you experiencing any other side effects besides severe and chronic pain, nausea, or severe and persistent muscle spasms as a result of treatment?

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HIPAA Compliant Authorization:

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I hereby authorize you to release and discuss any and all medical health treatment records and information that you have in your possession regarding my health condition, including but not limited to my health history, my health treatment, your findings regarding my health, records of consultations that I have had, records of medication prescribed for me, X-rays taken of me, to the physicians, hospitals, and other facility treating me for the purpose of providing medical advice and treatment. I understand a covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR164.508 (b)(4) applies. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it before it is delivered. If I do not revoke it, this Authorization will expire one year after the date on which I signed it. I understand that information disclosed through this Authorization may be subject to re-disclosure and no longer protected by the privacy protections associated with HIPAA and 45 CFR 164.508. This document shall be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I authorize you to discuss my protected health information with anyone whose name or relationship I write below:

Patient Signature:_____ **Date:**_____

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Physician Review

Ht:_____ **Wt:**_____ **BP:**_____

Notes:

_____
_____
_____
_____

Physician Signature:_____ **Date:**_____