



TIMEWISE MEDICAL

8530 Eagle Point Blvd. Suite 100 Lake Elmo, MN 55042

Phone: 651-333-9133 | Fax: 1-651-560-7013 | frontdesk@timewisemedical.com |

Patient Information:

Name: _____ Date of Birth: _____ Sex: M F
(First name) (Middle Initial) (Last Name)

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Can we leave a detailed message? : Yes No

Email Address : _____

Emergency Contact Information:

Emergency Name: _____ Relationship: _____
(First name) (Middle Initial) (Last Name)

Emergency Address: _____ City: _____ State: _____ Zip: _____

Emergency Phone Number: _____

Please list your qualifying Medical Condition: _____

Severity of symptoms:

1 2 3 4 5 6 7 8 9 10

Frequency of symptoms (rare, intermittent, frequent, constant):

Please describe your symptoms: _____

Pregnant? YES NO

Diagnosed with schizophrenia or schizoaffective disorder? YES NO

How did you hear about us? _____



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Are you allergic to any medication? Yes No (If yes, please list below) _____

Current Medication(s): _____

Past Medical History: (Please check all that applies)

- | | | | | |
|--------------------------------------|--|---|--|--------------------------------------|
| Diabetes <input type="checkbox"/> | Chest Pain/Angina <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Pacemaker <input type="checkbox"/> |
| Headache <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Cancer <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | Heart Palpitations <input type="checkbox"/> | Stroke/CVA/TIA <input type="checkbox"/> | Seizure <input type="checkbox"/> |
| HIV/AIDS <input type="checkbox"/> | Stomach Ulcer <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Hepatitis <input type="checkbox"/> | Asthma/COPD <input type="checkbox"/> |
| Depression <input type="checkbox"/> | Heart Surgery <input type="checkbox"/> | Congestive Heart Failure <input type="checkbox"/> | Peripheral Vascular Disease <input type="checkbox"/> | |
| Blood Clots <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> | | |

Other: _____

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Grandparents: _____

Social History:

Marital Status: _____ Occupation: _____

Smoke: Never Ex-Smoker Current Smoker How many packs per day? _____

Alcohol: Never Occasional: Frequent

Additional Information: _____

Doctor's Signature: _____ Signature of Patient: _____

ROS**Please check all CURRENT positive findings****Patient please fill out:**

Constitutional	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Poor appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight gain <input type="checkbox"/> Insomnia <input type="checkbox"/> Night sweats	Gastrointestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in the stool <input type="checkbox"/> Frequent heartburn <input type="checkbox"/> Trouble swallowing
Eyes	<input type="checkbox"/> Blurry vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye redness <input type="checkbox"/> Decrease in vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Double Vision	Genitourinary	<input type="checkbox"/> Increased urinary frequency <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <input type="checkbox"/> Urinary retention <input type="checkbox"/> Frequent UTI's
ENT	<input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Tinnitus <input type="checkbox"/> Sinus problems	Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin sores or ulcers <input type="checkbox"/> Itching <input type="checkbox"/> Skin thickening <input type="checkbox"/> Nail changes <input type="checkbox"/> Mole changes
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Heart murmur <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling in the legs or feet	Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle aches <input type="checkbox"/> Frequent leg cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Back pain
Respiratory	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> History of Tuberculosis <input type="checkbox"/> Excess sputum production	Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alcohol or drug dependence <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Panic attacks <input type="checkbox"/> Use of anti-depressants
Endocrine	<input type="checkbox"/> Goiter <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Increased thirst <input type="checkbox"/> Change in skin pigment <input type="checkbox"/> Excess sweating	Neurological	<input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness/vertigo <input type="checkbox"/> Stroke <input type="checkbox"/> Slurred speech
Hem/Lymphatic	<input type="checkbox"/> Low blood count <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Transfusions <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Blood clots	Allergic/ Immune	<input type="checkbox"/> Allergic reactions <input type="checkbox"/> Hay fever <input type="checkbox"/> Frequent infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV Positive <input type="checkbox"/> Positive Tuberculin Skin Test (PPD)



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Previous therapies for Qualifying Condition

Please circle all that apply:

- Chiropractic services
- Physical Therapy
- Acupuncture
- Injections
- Massage
- Surgery
- Behavioral Therapy
- Psychology/ Psychiatry/ Therapy
- Trigger Point Injections
- Medication
- Spinal Cord Stimulator
- Yoga
- Chemotherapy/ Radiation
- CPAP Machine

PLEASE EXPLAIN THE PROCEDURES AND THE RESULTS THAT YOU EXPERIENCED WITH EACH THERAPY:

MEDICAL CANNABIS CERTIFICATION FOLLOW UP APPOINTMENTS

Greetings and welcome to our practice at TimeWise Medical. After your Certification/Approval commences should you have questions from now until re-certification 1 calendar year later please make an appointment. There is no charge for follow-ups after Certification and before Re-certification for questions about medications you are currently taking, about optimizing the dose of the Medical Cannabis, or anything else. This is included. Follow up can occur on the phone, over Internet, or Face-to-Face as needed.

Pregnant? YES NO

Diagnosed with schizophrenia or schizoaffective disorder? YES NO

FREEDOM FROM OPIATES

[Http://timewisemedical.com/groundbreaking-observational-study-launched-replacing-opioids-medical-cannabis/](http://timewisemedical.com/groundbreaking-observational-study-launched-replacing-opioids-medical-cannabis/)

Please refer to Minnesota Department of Health website regarding possible side effects.

Patient Signature: _____

Date: _____