TIMEWISE MEDICAL

8530 Eagle Point Blvd, Suite 100, Lake Elmo, MN 55042 3523 45th St. S Suite 100, Fargo, ND 58104
15310 Amberly Dr., Suite 250, Tampa, FL 33647 2718 Gateway Ave, Suite 103, Bismarck, ND 58503
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 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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Height:_____ **Weight:**_____

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 □	Chest Pain/Angina □	High Blood Pressure □	Heart Disease □	Pacemaker □
Headache □	Kidney Stones □	High Cholesterol □	Kidney Disease □	Cancer □
Arthritis □	Osteoporosis □	Heart Palpitations □	Stroke/CVA/TIA □	Seizure □
HIV/AIDS □	Stomach Ulcer □	Liver Disease □	Hepatitis □	Asthma/COPD □
Depression □	Heart Surgery □	Congestive Heart Failure □	Peripheral Vascular Disease □	
Blood Clots □	Tuberculosis □	Thyroid Disease □		

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: _____

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Previous therapies for Medical 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:

ROS

Please check all CURRENT positive findings

Patient please fill out:

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

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/

Please refer to your state's Department of Health website regarding possible side effects.

Patient Signature: _____

Date: _____