Welcome to Southwest Medical Marijuana Evaluation Center

Proudly serving Arizona since 2011!

- **Your appointment**
  - This packet contains paperwork that needs to be completed. If you do not get a chance to complete it prior to coming in for your appointment, please arrive 30 minutes early to do so
  - Please make sure you bring an **Az State issued driver's license, state ID or Valid US passport** with you. In addition, if you are on the **SNAP** program, please bring your card or approval letter if your card does not have your name on it
  - Your appointment time with the doctor will be approximately 15 – 20 minutes. Your total time at the office will be approximately 45 minutes – so plan accordingly. If we are running later than that we will advise you at check in
  - Your appointment will be with an Arizona state licensed physician
  - During your appointment your physician will review your medical history, conduct relevant examinations as they pertain to your qualifying condition and, most importantly, provide you with information regarding the appropriate strain and use of medical marijuana. In addition, other treatment options the physician feels would assist you will be recommended.
- **What's Next?**
  - Once you have completed your appointment with your physician, you will go through the checkout process with one of our knowledgeable staff who will take your photo and documentation necessary for us to process your application with the state. So you do not have to worry about a thing - ***we handle all the administrative work for you - efficiently & timely***
  - After your application has been approved by the state (up to 5 day process), in approximately 10 business days you will receive your card in the mail
  - Once you have your card, you can go to a state licensed dispensary (note: the state will send an attachment with your approval email that has a list of these so watch for that in your inbox or spam folder) and obtain your medicine based on the recommendation of your physician
  - An annual renewal is required, so approximately 10 months from your appointment, you will receive an email from us reminding you it is time to come back in. If you have been to another physician and/or chiropractor for your qualifying condition since we saw you last, your physician will want to review those records. Please complete a records release to start this process.
- **Other services**
  - Each of our physicians at SWMMEC specialize in different areas in addition to the recommendation of cannabis. Therefore, at the time of your appointment, your physician may recommend other very important treatment options for you that may include supplements and follow up care. Follow up appointments can be scheduled during the checkout process.

Our mission is to provide the medical marijuana patient with dignity, professionalism, confidentiality and compassion

Southwest Medical Marijuana Evaluation Center

Health Questionnaire

Personal Information:

Date_____ Name _____ Date of Birth_____ Age ___

Height: Weight: Gender: Male / Female

Address _____ City _____ State/Zip _____

Best Contact #: _____ Email Address: _____

Occupation: _____ **FEMALES ONLY: CURRENTLY PREGNANT? Y / N**

Medical History

Current medical concern: (List the medical problem(s) for which you use or, would like to use medical marijuana; **include year of onset of symptoms**)

_____

_____

_____

Treatments: check any treatments you use / have used for your condition: ___ Surgery ___physical therapy ___chiropractic _____massage ___herbal therapy ___counseling ___ exercise ___ acupuncture: _____ other _____

Primary Care Provider: Please give the name & address of your healthcare provider (includes chiropractor/psychologist/acupuncturist etc.) Please also **list the date you were last seen by that provider;**

_____

_____

_____

Prescription Medications: include the strength and dosing instructions

_____

_____

_____

Non Prescription and Supplements:_____

_____

_____

Allergies to medications / indicate **what the allergy causes**, eg. Hives, rash , nausea etc)_____

_____

_____

Hospitalization / **Surgical History:** list any hospitalizations / surgeries that you have had (**include dates**):

_____

_____

_____

Social History : Do you currently use: Tobacco Yes/ No # of cigarettes per day _____Alcohol Yes/ No # of drinks per week _____ Exercise 3-5x/wk Yes/No

Family History: Do your parents, siblings or children have/had any significant medical/psychological problems? Yes No If yes, please explain: _____

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Review of Systems

Do you have or have you ever had any of the following medical problem?

___ Asthma/Lung Disease ___ Cancer ___ HIV/AIDS ___ Diabetes ___ Hepatitis ___ Epilepsy/Seizures
___ Stroke ___ Liver Disease ___ Kidney Disease ___ High Blood Pressure ___ Heart Disease
___ Sleep Disorders ___ Substance Abuse ___ Intestinal Disorders (IBS, Ulcers) ___ Psychiatric Disorders

	NORMAL	**check if ABNORMAL**
General	□	□fever □chills □night sweats □fatigue □wt change □appetite change □ insomnia
Head/Face	□	□sinus pain □sinus drainage □ facial pain
Ears	□	□earache □ear discharge □decreased hearing □tinnitus
Eyes	□	□eye pain □red eye □blurred vision □double vision □eye discharge
Oral Cavity	□	□sore throat □swallowing difficulty □toothache □gum swelling □Hoarseness
Skin	□	□rash □itching □bites □sores □redness □acne □bruising □varicose veins
CV	□	□chest pain □palpitation □edema □anemia
Resp	□	□cough □breathlessness □wheezing □sputum □bloody sputum
GI	□	□Pain □ nausea □ vomiting □ bloody vomiting □diarrhea □ bloody/dark stools □mucus stools □Gas/bloat □indigestion
MusculoSkeletal	□	□joint pain □ joint swelling □redness □limited movement □ leg cramps □**Pain Scale today: None 1 2 3 4 5 6 7 8 9 severe** (circle #)
CNS	□	□headache □migraines □ weakness □ numbness □ tingling □ poor balance/coord
Genitourinary	□	□frequency □urgency □ burning □bloody urine □discharge (females only) □irreg periods □ **currently pregnant** □ breastfeeding
Psych	□	□mood □ interest □concentration □ sleep problems □ Suicidal ideation □anxiety □ **SCHIZOPHRENIA**

Explain any abnormals indicated from above:

_____

_____

_____

_____

Southwest Medical Marijuana Evaluation Center

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box. If an activity does **not cause pain or if pain does not affect an activity**, leave **box blank.**

[1] This activity causes **some pain**, but it is only a minor annoyance.
[2] This activity causes a **significant amount of pain**, but I can do it.
[3] I **cannot perform this activity** due to pain and disability.

Self Care and Personal Hygiene

[ ] bathing/showering	[ ] brushing teeth	[ ] putting on shoes	[ ] eating	[ ] doing laundry
[ ] grooming hair	[ ] making the bed	[ ] putting on pants	[ ] dishes	[ ] going to toilet
[ ] washing face	[ ] putting on shirt	[ ] cooking	[ ] taking out trash	

Physical Activities

[ ] standing	[ ] walking	[ ] reaching	[ ] bending right	[ ] twisting right
[ ] sitting	[ ] squatting	[ ] bending forward	[ ] bending left	[ ] twisting left
[ ] reclining	[ ] kneeling	[ ] bending back	[ ] looking left	[ ] looking right

Functional Activities

[ ] carrying small objects	[ ] lifting weights off table	[ ] pushing/pulling while standing
[ ] carrying large objects	[ ] climbing stairs/incline	[ ] exercising upper body
[ ] carrying briefcase/purse	[ ] pushing/pulling while seated	[ ] exercising lower body
[ ] lifting object off floor		

Social and Recreational Activities

[ ] bowling	[ ] jogging	[ ] swimming	[ ] golfing	[ ] dancing
[ ] biking	[ ] hunting/fishing	[ ] competitive sports	[ ] gardening	
[ ] walking	[ ] horse riding	[ ] other: _____		

Difficulties with Traveling

[ ] driving in car	[ ] driving for long periods of time
[ ] riding as passenger	[ ] riding as passenger for long periods of time

I certify that the above responses are complete and accurate to the best of my knowledge: _____
Patient Signature

Physician's Signature: _____

Southwest Medical Marijuana Evaluation Center

Medical Marijuana (MMJ) History

Have you been evaluated by another physician (in any state) for MMJ ? Yes / No
If yes, list the name of the practice, doctor, and date seen: _____
Do you use MMJ to reduce or eliminate the use of any medications that have been prescribed for your medical condition? Yes/No If yes, which medication have you reduced or eliminated and why? _____
_____
How often do you use MMJ ? ( ) ____ x day ( ) ____ x/ week ( ) _____ x/month

What is your preferred method of using MMJ? ( ) smoke ( ) vaporizer ( ) ingested ( ) topical ( ) tincture
How effective is MMJ for your medical problem? ( ) very effective ( ) effective ( ) only somewhat effective
How does MMJ improve the quality of your life? _____
_____

Additional Information

Do you have an open court case regarding marijuana? Yes / No Are you currently on probation? Yes / No
Please provide any additional information that may be relevant for your physician to know:
_____
_____
_____

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today and, if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete and has been offered only for the purpose of gaining treatment of my medical condition. I further certify that I am not seeking marijuana for illegal purposes; I am not a reporter or member of the media working on a story; And, I am not a member of law enforcement seeking to investigate or build a case against my physician or anyone affiliated with my physician.

_____ _____
Patient Signature Date

_____
Print Name

Southwest Medical Marijuana Evaluation Center

PATIENT ACKNOWLEDGEMENT

I understand that: [please initial each item]

_____ The attending physician, staff and or representatives of Southwest Medical Marijuana Evaluation Centers (herein SWMMEC) are neither providing, dispensing nor encouraging me to obtain medical marijuana.
_____ The attending physician, staff and or representatives of SWMMEC will NOT be providing or discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana.
_____ The physician, staff and representatives of SWMMEC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.
_____ Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the state. It is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.
_____ I acknowledge that I am a resident of Arizona, I am at least 18 years of age and have not misrepresented any information to SWMMEC.
_____ I acknowledge that I am not an agent of law enforcement, state or federal government here for the purpose of investigation or entrapment.
_____ I acknowledge that I am not recording any portion of my visit with SWMMEC nor do I possess any recording equipment. I understand SWMMEC does not approve of such action. I further acknowledge that, without express written permission of SWMMEC, it is illegal to film or record in this office with video camera, cell phone or any other recording devices, including still image, video or audio. Any such action is a direct violation of HIPAA regulations and patient/ doctor confidentiality.
_____ I acknowledge that it is up to me to become a patient of SWMMEC and am in no way being coerced to do so.
_____ I acknowledge that marijuana, even if used for medical purposes, is illegal under Federal law and has been placed on Schedule 1 by the US FDA. As such, marijuana is considered to have no medical benefit and a significant potential for abuse. I assume all responsibility for any violation of Federal law.

_____ _____
Patient Signature Date

_____
Print Name

Southwest Medical Marijuana Evaluation Center

INFORMED CONSENT AND RELEASE FROM LIABILITY

I am being evaluated for a physician's recommendation for medical marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I have been informed of and understand the following: [please initial each item]

_____ I must be an Arizona resident and over the 18 years of age to obtain an approval or recommendation for the use of cannabis (medical marijuana) under Arizona law. If I am under 18 years of age I must have parental consent and authorization for the use of medical marijuana.

_____ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Arizona, which have modified their state laws to treat marijuana as a medicine.

_____ Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

_____ The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

_____ Potential **side effects** from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may increase eating, alter my perception of time and space and impair my judgment.

_____ I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____ I agree to contact a physician/emergency medical facility if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact a physician/emergency medical facility if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

_____ Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung,

mouth and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician. It is the recommendation of the physicians at SWMMEC to not smoke medical marijuana. Safer, less harmful methods of administration include; ingesting (edible), vaporizing and or tinctures.

_____ The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

_____ Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit I could be developing a dependency on marijuana, and should seek medical assistance.

_____ Signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

_____ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to the nearest emergency room.

_____ If SWMMEC subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with SWMMEC and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

_____ I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

I acknowledge the SWMMEC physician informed me of the nature of a recommended treatment, including but not limited to, recommendations regarding medical marijuana. The SWMMEC physician also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the SWMMEC physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

Furthermore, I, the undersigned (including my heirs, or anyone acting on my behalf), hold SWMMEC, the physician and his/her principals, agents, employees and management, harmless and release them from any liability resulting in any way whatsoever from my use of marijuana. This release of liability includes, but is not limited to, any bodily or psychological injury, whether known or unknown, as well as legal and/or employment problems resulting from my use of marijuana.

_____ _____

Patient Signature Date

_____

Print Name

Az Department of Health Services Patient Application Form

(PLEASE **WRITE CLEARLY** / AN INPUT ERROR WILL DELAY YOUR CARD AND COST YOU ADDITIONAL $)

The information on this form will be used to process your application with the state.

Medical Marijuana Renewal Information

(New patients leave this section blank)

Current Az Registry Card #: _____ Exp Date: _____

Driver's License / State ID Information

Az Driver's License #: _____ **OR** Az State Identification #: _____

DOB: ____/_____/_____Issue Date: _____/_____/_____

Patient Information

First Name: _____ Last Name: _____

Mailing Address: _____ City:_____

State: _____ Zip Code: _____

EMAIL (required): _____ Best Phone Contact #: _____

Note: The state requires a street address when using a PO Box – please supply or your application will be delayed

Caregiver Information

(Only complete this section if you plan on having a MMJ caregiver - $200 additional fee required)

Date of Birth: _____ Gender: _____

First Name: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ County: _____ State: _____

Other

You must select Yes or No – DO NOT LEAVE THIS SECTION BLANK

*Food Stamp Discount: Yes_____ No_____ / Cultivation privileges: Yes_____ No_____ / Homeless: Yes_____No_____

*must have a food stamp card w/your name on it, or, your eligibility letter in your name in order to get the state's discount fee of $75

I give my permission for SWMMEC to process my state application for a Medical Marijuana ID Card. In addition, I agree that the above information is accurate. If the application can't be processed due to illegibility, **I may be responsible for an additional fee of $20 to re-run the application.**

Signature: _____ Date: _____

Print Name: _____

Note: This document will be destroyed once the application process with the state has been completed. Contact the office if you need your application ID # for any reason. The application ID # starts with AZQP….

Print Form

ARIZONA DEPARTMENT OF HEALTH SERVICES

MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA PATIENT ATTESTATION

I, _____, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed