Dr. Junella Chin & Dr. Jose Camacho
O: 212-966-6655

NEW PATIENT HEALTH HISTORY

Name: _____Date of Birth:_____ Age: _____

STATE CURRENT HEALTH CONCERN(S):

FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

Current Symptoms (be as descriptive as possible)

_____

_____

_____

_____

What makes it better, what makes it worse?

_____

_____

How did this condition start?

_____

_____

_____

What type of workup have you had (doctors seen, tests performed, etc.)?

_____

_____

_____

What treatments have you tried? How well have they worked?

_____

_____

_____

CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage please):

_____

_____

_____

_____

CANNIBIS HISTORY
Are you currently using marijuana? Yes No Age at first use of cannabis? _____

Dosage (i.e. 2-3 puffs three times daily, or ¼ ounce per week)

_____

Delivery System (i.e. pipe, joint, vaporizer, tincture, etc.)

_____

High/Low Quality, Strain?

_____

Have you had any adverse affects from cannabis?

_____

Have you ever had a reaction from cannabis? anxiety, depression, paranoia, other_____

CURRENT MEDICAL CARE: Primary Care Provider (name, practice name or location):

_____

Approximate date of last physical examination: _____ by whom? _____

Would you like us to send a copy of your office visit note to your PCP or other providers? YES NO

I am or have been treated by a: Talk therapist _____ Social worker _____ Psychiatrist _____ Pain specialist_____

Heart specialist_____ Nerve specialist_____

Other health care professional(s) you are seeing and for what conditions: _____

_____

ALLERGIES? (include reactions to medicines): _____

_____

PAST MEDICAL HISTORY: Please list all major illnesses, injuries, traumas (including emotional), and surgeries w/ year

_____

_____

_____

_____

LIFESTYLE:

I have finished: Middle School____ High School ____ College ____ Post-Graduate Degree ____

I am: Employed____ Unemployed____ Disabled____ Other_____

How many hours of sleep do you get a night? _____ Trouble sleeping or sleeping too much? _____

How many cups or glasses do you drink per day: water:_____ milk:____ caffeinated beverages:_____

How many alcoholic beverages do you drink per week: _____Tobacco: _____ Drugs_____

What substances have you used in the past:

Cocaine_____ Heroin_____ RX drug abuse_____ Mushrooms_____ Acid_____ Ecstasy_____

ETOH_____ Other_____

How much exercise per week (what kind?) _____

What do you do for fun? _____

Any recent major life changes? _____

FAMILY MEDICAL HISTORY: (please list any conditions that run in the family, indicate if alive or deceased)

Mother_____

Father _____

Siblings_____

_____

MEDICAL HISTORY

EYES
- ☐ Failing vision
- ☐ Double or blurred vision
- ☐ Squinting/"crossed" eyes/
- ☐ Asymmetric gaze
- ☐ Eye pain
- ☐ Eye infections
- ☐ Lose place when reading
- ☐ Poor reading comprehension
- ☐ Eyestrain or fatigue from reading
- ☐ Headache from reading
- ☐ Glasses or contacts
- ☐ Monovision/Progressive lenses

ENT
- ☐ Decreased hearing
- ☐ Loud voice
- ☐ Snoring/Mouth breathing
- ☐ Ringing/Buzzing in ears
- ☐ Ear infections
- ☐ Allergies/Hay fever/Runny nose
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Frequent sore throats
- ☐ Prolonged hoarseness
- ☐ Speech problems

CARD-PULM
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath on lying flat
- ☐ Chest pains
- ☐ Heart murmurs
- ☐ Palpitations
- ☐ Swollen ankles
- ☐ Fainting spells
- ☐ Leg pain when walking
- ☐ Varicose veins/Phlebitis

GI
- ☐ Eating disorder
- ☐ Recent loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Persistent nausea/vomiting
- ☐ Ulcers
- ☐ Chronic abdominal pain
- ☐ Recent change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or tarry stools
- ☐ Red blood in stools
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Gall bladder trouble
- ☐ Jaundice/Hepatitis
- ☐ Hernia

ENDO
- ☐ Chronic fatigue
- ☐ Recent weight loss
- ☐ Excessive weight gain
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Diabetes

NEURO
- ☐ Convulsions/Seizure
- ☐ Stroke
- ☐ Tremors
- ☐ Muscle weakness
- ☐ Numbness/Tingling sensation
- ☐ Frequent headaches
- ☐ Clumsiness

MS
- ☐ Joint pain
- ☐ Scoliosis/Kyphosis
- ☐ Arthritis
- ☐ Gout
- ☐ Cold or numb feet
- ☐ Involved in contact sports

DERM
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Unusual moles

PSYCH/EMOTIONAL
- ☐ Difficulty Sleeping
- ☐ Nightmares
- ☐ Nervousness/Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Memory loss
- ☐ Moodiness
- ☐ Phobias
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/breath holding/
- ☐ Jealousy

ILLNESSES
- ☐ Mumps
- ☐ Measles
- ☐ German measles
- ☐ Chicken pox
- ☐ Polio
- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ TB
- ☐ Meningitis

HABITS
- ☐ Alcoholism
- ☐ Alcohol.....
- ☐ Cigarette .....packs/day
- ☐ Coffee/Tea .....cups/day

HEME
- ☐ Anemia
- ☐ Malaria
- ☐ Bruise easily/Bleeding
- ☐ Mononucleosis
- ☐ Unexplained lumps
- ☐ Fever/Chills/Excessive sweating

GU
- ☐ Bed wetting
- ☐ Bladder infections
- ☐ Kidney infection
- ☐ Pain on urination
- ☐ Poor control of urination
- ☐ Decreased force of urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Discharge from penis or vagina
- ☐ Sexually transmitted disease

FEMALE ONLY:

Number of pregnancies .....
Number of live births.....
Number of miscarriages .....
Method of birth control.....
Age of onset of menses.....
Flow: ☐ Light ☐ Moderate ☐ Heavy
- ☐ Period Not Regular
- ☐ Length of Flow .....
- ☐ Length of Cycle.....
- ☐ Pain/bleeding with intercourse
- ☐ PMS (medium to severe)

STRESS

Check any of the following that occurred in your family the past year:

☐ Marriage ☐ Births ☐ Serious illness
☐ Divorce ☐ Deaths ☐ Separation
☐ Job loss ☐ Move ☐ Other.....

DENTAL
- ☐ Orthodontic treatment
- ☐ Dental extractions
- ☐ Crowns
- ☐ Root canal work
- ☐ Fillings
- ☐ Bridgework
- ☐ Retainer/Night guard
- ☐ Gum problems

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NEW PATIENT INFORMATION & CONSENT FORM

Patient's name_____ M____ F___ Birth Date _____

Patient's address _____

_____

Email:_____

Telephones: home_____ work_____ cell _____

single___ married___ other___ children _____

Occupation _____

Patient's employer or school _____

Patient's Primary Care Physician (and/or Referring Physician) _____

Emergency Contact Info:

Name: _____ Relationship: _____ Phone: _____

Referred by: _____

I, _____ understand that payment for services by this office is solely my responsibility, regardless of any insurance coverage I may have. I authorize the release of any medical or other information necessary to process insurance claims, or a release of records to medical review agencies as required by law. I voluntarily and knowingly consent to and request outpatient treatment, which may encompass diagnostic tests and medical treatments deemed appropriate by the treating physician. I understand that such services are to be performed by the attending physician or by assistants designated by said doctor. I further authorize and consent to assistants and other personnel, to undertake this service and care as indicated by my attending physician.

_____ _____

Signature of Patient, Parent or Guardian Date

CONSENT TO TREATMENT WITH MARIJUANA FOR MEDICAL PURPOSES

I, _____, ("Patient") am requesting Junella Chin, D.O. or another Canal Group Inc. Physician (the "Physician") to certify me /my child/ my legal ward as a qualifying patient under the New York or Connecticut Medical Marijuana Act and to treat Patient's debilitating medical condition as Patient uses marijuana for medical purposes. In requesting the Physician to continue treating Patient as Patient uses marijuana for medical purposes, I assume full responsibility for any and all risks of this action related to Patient's current medical condition.

I understand that marijuana is not approved by the Federal Food and Drug Administration for medicinal purposes and may contain unknown quantities of active ingredients and may potentially contain contaminants and/or impurities. I understand that the Physician may not be knowledgeable of all the associated risks involved in the use of a non- FDA approved substance such as marijuana. I acknowledge that there is controversy in the medical/scientific literature available regarding the usage of marijuana for medical purposes and that more research is currently being conducted.

I understand that although the New York or Connecticut law has approved the limited use of marijuana for medical purposes, its use is not approved under federal law, and that the current and future enforcement action of federal law enforcement officials is uncertain.

Date: _____

_____ Signature of Patient or Patient's Parent/Legal Guardian