Lina A. Kiley, MD, FACOG, URPS
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HISTORY FORM

DATE OF VISIT_____

NAME_____ DATE OF BIRTH_____

ADDRESS:_____

PRIMARY DOCTOR _____

ALLERGIES TO MEDICATIONS/ENVIRONMENTAL ALLERGIES

_____
_____

MEDICATIONS

_____
_____
_____
_____

MEDICAL CONDITIONS

_____
_____
_____
_____
_____

SURGERIES

_____
_____
_____

WHAT IS THE REASON FOR YOUR VISIT TODAY?

_____

HAVE YOU EVER USED MEDICAL MARIJUANA IN THE PAST? (CIRCLE) yes / no
IF YES, ANY DIFFICULTIES OR UNDESIRED EFFECTS? (CIRCLE) yes / no

DO YOU SUFFER FROM INSOMNIA? (CIRCLE) yes / no
DO YOU EXPERIENCE PAIN ON A FREQUENT BASIS THAT DOES NOT RESPOND WELL TO OTHER MEDICATIONS? (CIRCLE) yes / no
DO YOU EXPERIENCE MUSCLE SPASMS OR TREMORS FREQUENTLY? (CIRCLE) yes / no
HAVE YOU BEEN DIAGNOSED WITH NEUROPATHY? (CIRCLE) yes / no

PAGE 2 CCM H&P PATIENT NAME _____

TELEMEDICINE? (CIRCLE) yes / no

PHYSICAL EXAMINATION

PULSE_____ RR_____ BP_____ TEMP_____

WT_____ HT_____

GENERAL_____

HEENT _____

MUSCULOSKELETAL_____

NEUROLOGIC _____

ABDOMEN _____

PELVIC _____

EXTREMITIES _____

ASSESSMENT

_____
_____
_____

PLAN

_____
_____
_____
_____

PATIENT ID NUMBER (FLORIDA MARIJUANA REGISTRY) P_____

DATE OF FOLLOW UP _____

DOSING

_____
_____

_____ LINDA A KILEY, MD

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