# Christine Daecher, DO

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## ***IMPORTANT, PLEASE READ! This form will be mailed to you, but may not reach you before your appointment. ***

Name: _____ Date: _____

Your Certifying Appointment is scheduled for: M T W Th F _____
Day of the week, Month, date, year

At _____ AM / PM

**Please arrive 30 minutes prior to your appointment.**
**If you completed the paperwork prior to the day of your appointment, you can arrive 15 minutes prior to your start time. Please bring completed paperwork with you.

| Payment date: | Amount paid: | Cash/ CC or debit: | Card ending in: | Notes: |
|---|---|---|---|---|
| | | | | |
| | | | | |

- The Certification Examination for Medical Cannabis is **NOT a billable service to your insurance, Medicare, or Medicaid.**
- **There is no guarantee with this appointment that you will receive certification.**
- **There are no refunds.**
- **You may move/reschedule the appointment up to 48 business hours prior to the appointment**
- **If you miss or cancel less than 48 business hours prior to the appointment, you must pre-pay for another appointment to be rescheduled**
- **You will receive a confirmation phone call the business day prior to your appointment**
- **If you cancel the appointment prior to 48H before, you will not get a refund, but you may reschedule.**
- You will be required to have periodic follow up with Dr. Daecher to evaluate the effectiveness of medical cannabis and any possible side effects. These follow ups are **NOT a billable service to your insurance, Medicare, or Medicaid**
- Certification is dependent upon your medical diagnosis and supporting documentation from other physicians
- If the doctor certifies you, your certification will be prepared within 7 days of your visit and it will be dated for the day it is completed. If required medical records are not available at the time of your appointment, your certification will be completed within 30 days of your appointment and only after records are received and reviewed.
- **The office will attempt to obtain your medical records, but you may be asked to request them from your other doctors. The fax number above can be used for records.**

**THANK YOU!**

Staff Signature: _____ Date: _____

Patient name: _____ Date: _____

SSN: _____

DOB: _____

Work/occupation, disability status: _____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

**1. What problems do you have today that you would like to have addressed?**

_____

_____

_____

**2. What medical problems do you have? (please check and explain below)**
**What surgeries have you had?**

| | | | |
|---|---|---|---|
| High Cholesterol | | Cancer | |
| Heart disease / Heart Attack | | Seizure / Epilepsy | |
| Stroke / mini-stroke | | Kidney disease | |
| high blood pressure | | Liver disease | |
| carotid artery disease | | Heart burn / GERD | |
| peripheral vascular disease | | Back pain | |
| blood clots / PE | | Arthritis | |
| aneurysm | | Vision problems | |
| Passing out | | Skin conditions | |
| Falls / Gait dysfunction | | Irritable Bowel | |
| Pneumonia | | Anxiety | |
| Asthma | | Depression | |
| COPD / emphysema | | Diabetes | |
| Tuberculosis (TB) | | Thyroid Disease | |
| Stomach ulcers | | Anemia | |
| | | HIV | |

**Other? Please explain any above. List all SURGERIES with dates.**

_____

_____

_____

_____

**3. Do you see any other specialists / physicians?**

**Name, type of doctor:**

_____

_____

_____

_____

**4. Do these conditions run in your family? Who?**

| | |
|---|---|
| Alcohol Use Disorder | |
| Opioid Addiction | |
| Other Drug Use? | |
| Depression | |
| Anxiety | |
| Schizophrenia | |
| Other Mental Health Conditions? | |

**5. Please complete below.**

**Current or previous smoker?** _____
Packs a day? _____
Years smoking? _____
Quit date?

**Alcohol use?** _____
How much? _____
How many years? _____

**Drug use?** _____
What drugs? _____
How much? _____
How often? _____

**Current marijuana use?** YES / NO

**Are you a caretaker for someone?** _____
**Do you have a caretaker?** _____
**Marital Status:** _____

**6. Drug (include prescription drugs used by you even if not prescribed to you. Include any street drugs as well.**

| | **Dose or amount** | **Frequency** |
|---|---|---|
| Snake oil | 500mg | daily |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**What medications do you have an allergy or intolerance?**

**7. Please check below which of the following are a concern to you now or have had within the last 6 months.**

weight gain _____
weight loss _____
fevers / chills _____
weakness _____
fatigue _____
change in appetite _____
night sweats _____
day sweats _____

vision change _____
eye swelling _____
eye discharge _____
excessive tearing _____
eye dryness _____
loss of peripheral vision _____

shortness of breath with activity _____
shortness of breath at rest _____
heart arrythmia _____

cough _____
excessive sputum _____
wheezing _____
Pain with deep breathing _____
pain with deep breathing _____
history of TB _____

snoring _____
restless legs _____
insomnia _____
excessive sleeping/sleepiness _____

**Continued:**

eye itching _____
eye pain _____

nose bleeds _____
bleeding of gums _____
toothache _____
sinus problems _____
loss or decrease in hearing _____
ringing in ears _____
pain in ears, nose, mouth _____
sore throat _____

chest pain or chest pressure _____
palpations _____
heart murmur _____
difficulty breathing at night _____
ankle swelling _____
dizziness _____
passing out _____

muscle aches _____
swollen joints _____
red / inflamed joints _____
loss of motion of joints _____
muscle weakness _____
back pain _____
neck pain _____

skin dryness _____
skin redness _____
rash _____
moles _____
itching _____
excessive hair growth _____

confusion _____
forgetfulness _____
tremor _____
dizziness / vertigo _____
headaches _____
numbness / tingling anywhere _____
loss of use of limb _____
seizure/epilepsy _____

difficulty swallowing _____
abdominal pain _____
nausea _____
vomiting _____
diarrhea _____
constipation _____
blood in stools _____
black or tarry stools _____
increased gas (either end) _____
difficulty with bowel movements _____

kidney stones _____
pain with urination _____
increased urinary frequency _____
increased night urinating _____
bloody/pink urine _____
urinary incontinency _____
increased urinary urgency _____

nervousness / anxiety _____
depression _____
suicidal thought or actions _____

breast masses _____
nipple discharge _____
change in skin on breast _____
excessive hair growth _____
heat intolerance _____
cold intolerance _____
increased thirst _____
goiter _____
flushing _____

easy bruising _____
blood transfusion _____
anemia _____
enlarged glands / lymph nodes _____
frequent infections _____
seasonal allergies _____
food allergies _____

**Do you have any travel plans? Overseas? Elsewhere?**

_____

**Patient's signature**

_____

**Date**

_____

The above is true and correct to the best of my belief.

**Doctor's signature upon review.**

_____