ILERA HEALTHCARE

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www.ileraheathcare.com

New Patient Intake Form

FOR OFFICE USE ONLY: Consult/No Consult ☐ Form Reviewed by RPh _____ ☐ Patient Data Entered _____

DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Name: _____ Date of Birth: _____/_____/_____
(First) (Last) (MM) (DD) (YYYYY)

Address: _____ Phone Number: _____
(Street)

_____ Email: _____
(City) (State) (Zip)

IF APPLICABLE
PA Department of Health Certified Caregiver Name: _____

Caregiver Relationship to Patient: _____ Caregiver Phone: _____

How did you hear about Ilera Healthcare? ☐ Friend/Family ☐ Web Search

☐ Physician ☐ Social Media ☐ Leafly/Weedmaps ☐ Event (which event) _____

MARIJUANA CERTIFICATION

Medical Marijuana Card Issue Date: _____/_____/_____ Expiration Date: _____/_____/_____
(MM) (DD) (YYYY) (MM) (DD) (YYYY)

Name and Specialty of Approved Certifying Physician: _____

Facility Location: _____
(Street) (City)

Certifying Physician's Phone: _____

MEDICAL HISTORY	
I have the following approved medical condition(s) for medical marijuana in Pennsylvania:	
☐ Amyotrophic Lateral Sclerosis (ALS)	☐ Intractable Seizures
☐ Anxiety	☐ Multiple Sclerosis (MS)
☐ Autism	☐ Neurodegenerative Diseases
☐ Cancer, including remission	☐ Neuropathies
☐ Crohn's Disease	☐ Opioid Use Disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions
☐ Damage to the nervous tissue of the central nervous system (brain-spinal cord) with objective neurological indication of intractable spasticity, and other associated neuropathies	☐ Pain – Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain
☐ Dyskinetic & spastic movement disorder	☐ Parkinson's Disease
☐ Epilepsy	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Glaucoma	☐ Sickle Cell Anemia
☐ HIV/AIDS	☐ Terminal Illness
☐ Huntington's Disease	☐ Tourette's Syndrome
☐ Inflammatory Bowel Disease	

Please list any other medical conditions you are currently under treatment for and/or past surgical procedures:

_____

_____

FEMALES ONLY: Are you pregnant or trying to become pregnant or breastfeeding? ☐ Yes ☐ No

Any allergies (medications and/or food)? ☐ Yes ☐ No
If "YES", please provide information: _____

Please list any prescription medications you are currently taking, including over the counter (OTC), vitamins, and supplements:

MEDICATION NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

SOCIAL HISTORY

Have you used marijuana in the past? ☐ YES ☐ NO

Are you currently using marijuana? ☐ YES ☐ NO
If "YES", how often? _____ per month _____ per week _____ per day

Do you use any form of nicotine: ☐ YES ☐ NO
If "YES", what form and how often? Nicotine type: Nicotine Usage:

_____ _____ per _____

Do you drink alcohol? ☐ YES ☐ NO
If "YES", how often? Alcohol Usage: _____ drinks per _____

Do you use any other substance? ☐ YES ☐ NO
(example: opioids not prescribed to you, cocaine, LSD, etc.)
If "YES", what form and how often? Substance type: Substance Usage:

_____ _____ per _____

Other Comments: _____

FOR OFFICE USE ONLY

Date of Initial Consult: _____

30-day DOH Limit: _____ grams/30 days

30-day limit set initially set by Ilera HCP?

☐ YES ☐ NO

Name of Dispensary Employee for Initial Intake:

_____

Signature of Dispensary Employee:

_____

Any restrictions set by certifying physician? ☐ YES ☐ NO
If "YES", please list: _____

Comments: