1. Personal Information

First Name: ____________________ Middle Name: _______________ Last Name: ___________________

Physical Address: ____

City: _____________________________ State: _____________________ Zip Code: ________________

Mailing Address: ____

City: _____________________________ State: _____________________ Zip Code: ________________

Sex: o Male o Female Age: ________ Date of Birth: _________________ SSN: ____________________

o Married o Widowed o Single o Minor o Separated o Divorced o Partnered for ______ years

2. Contact Information

Home Phone: _______________________________ Cell Phone: ________________________________

May we leave a voice message: o YES o NO Alternate Message Phone: _________________________

Email Address: ____

IN CASE OF EMERGENCY CONATCT INFORMATION:

Name: ___________________________ Home Phone: _______________ Cell Phone: ________________

3. Insurance Information

As of January 1st, 2017 we no longer accept ANY insurance policies. However, in case a referral is needed please provide the following insurance information:

Name of Insurance: ____

Subscriber's Name: ____

Relationship to patient: ____

Date of Birth: __________________________________ SSN: ___________________________________

GENERAL CONSENT TO TREATMENT: By signing below, I authorize Milan L. Hopkins, M.D. staff to perform any examination, tests and procedures and to provide any medications, treatment or therapy necessary to assess, diagnose and treat me. I understand that I may still refuse any particular examination, test, procedure, treatment, therapy or medication. I may also be asked to sign additional forms giving consent to specific types of treatments or procedures. I also understand that the practice of medicine is not an exact science and that no guarantees can be made to me as to the results of my evaluation and/or treatment.

Patient/Parent/Guardian Signature: _______________________________________ Date: ______________

Please Print Name: _________________________________Relationship to Patient: ____________________

4. Family History:

Date of last Physical Examination: ______________________________

What is your reason for this visit? ______________________________

Age, Health Status or Cause of Death:

Mother: ____

Father: ____

Brother(s): ____

Sister(s): ____

Check any illnesses which have occurred in any of your **Blood Relatives:**

o Allergy   o Bleeding Tendencies   o Cancer   o Diabetes   o Heart Disease   o High Blood Pressure

o Kidney Disease   o Nervous Illness   o Stroke   o Other

5. Social History

Occupational History (5 years)

	Year:	Occupation:
Current		
Previous		
Previous		
Previous		
Previous		

Education

Graduated	Grammar School	High School	AA	BA	MD	PhD
Yes						
No						

7. MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past years

General

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Numbness
- Sweats

Skin

- Bruise Easily
- Hives
- Itching/Rash
- Change in Moles
- Scars
- Sore that won't heal

Muscles/Joint/Bone

Pain, Weakness, Numbness in:

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

Cardiovascular

- Chest Pain
- High/Low Blood Pressure
- Irregular/Rapid Heartbeat
- Poor Circulation
- Swelling of Ankles
- Varicose Veins

Gastrointestinal

- Poor Appetite
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Thirst
- Gastrointestinal
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

Eye, Ear, Nose, Throat

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache/Ear Discharge
- Hay Fever
- Hoarseness
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision-Flashes/ Halos

Mental

- Anxiety
- Hallucinations
- Panic Attack
- Paranoia
- Other

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

Men Only

- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore Penis
- Other

Women Only

- Abnormal Pap Smear
- Bleeding Between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other

Date of last menstrual period:

____

Date of last Pap Smear:

____

Have you had a mammogram?

____

Are you pregnant? _______________

Number of children: ______________

8. Medication/Allergies

List allergies to medications or substances:

o ____ o ____

o ____ o ____

Pharmacy of Preference: ____ City: ___________________________

Pharmacy Phone Number: ____

List medications you are currently taking:

Medication	Inject/Ingest	Dosage	Time/Day	Prescriber	Note

Taken for the following

o Anxiety o Blood Pressure o Diabetes o Joint or Back Pain o Mental Problems

o Muscle Spasm o Pain o Seizures o Stomach or Intestine Digestion o Other

9. Signatures

To the best of my knowledge, the information above is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Patient/Parent/Guardian Signature: ____ Date: ________________

Please Print Name: ___________________________________Relationship to Patient: ______________________

Milan L Hopkins MD
a medical corporation
9425 Main St. Upper Lake CA
P.O. Box 638 Upper Lake, Ca. 95485
Phone (707)275-2366 Fax (707)275-9043

PATIENT'S STATEMENT

I, ____________________________________, do not currently have a Primary Care Physician. I am choosing Milan L. Hopkins, M.D. as my primary Care Physician.

Patients Signature: ______________________________________ Date: __________________

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PATIENT ACKNOWLEDGEMENT

(Please initial each item)

I understand that:

(*initials*)

______ The attending physician, staff and or representatives of Milan L. Hopkins, M.D. are neither providing, dispensing nor encouraging me to obtain medical marijuana.

______ The attending physician, staff and or representatives of Milan L. Hopkins, M.D. will NOT be providing or discussing information regarding dispensary, co-op, delivery service, or any other way to obtain marijuana.

______ The attending physician, staff and or representatives of Milan L. Hopkins, M.D. 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 medical use of marijuana, there is a renewal date specified by the physician. It is my responsibility to see the physician to assess the possible continuance of marijuana use beyond the term of approval.

______ I acknowledge that Milan L. Hopkins, M.D. may contact any other primary physician who is currently treating me.

______ I acknowledge that it is up to me to become a patient of Milan L. Hopkins, M.D. If I decide not to become a patient, or if Milan L. Hopkins, M.D. elects to not issue me a medical marijuana recommendation after my evaluation, there will be a $25.00 office visit charge. In the event that I do pay and elect to be a patient of Milan L. Hopkins, M.D. there will be no refunds.

Patient Signature: ____ Date: ______________________

Patient Name Printed: ____

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AUTHORIZATION FOR RELEASE OF INFORMATION

(Please initial each item)

Please initial next to each entry to which you agree:

(*initials*)

______ I hereby authorize Milan L. Hopkins, M.D. to disclose and verify my records as a patient to a marijuana dispensary or co-op for the purpose of obtaining marijuana for medicinal purposes. I understand that this authorization is valid for the period of time for which the recommendation for marijuana has been issued by Milan L. Hopkins, M.D. This release authority applies to any information governed by both the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 USC 1320d and 45 CFR 160-164 and/or the California Confidentiality of Medical Information Act (CMIA), California Civil Code §§56-56.37

_______ I hereby authorize Milan L. Hopkins, M.D. to verify my status as a patient via the Milan L. Hopkins, M.D. online or phone-in Patient Verification System. I understand that this authorization is valid for the period of time for which the recommendation for marijuana has been issued by Milan L. Hopkins, M.D.

______ I hereby authorize the use and disclosure of my physician patient records, except for personal identifying information, for use in data analysis of medicinal marijuana-treated patients.

______ I hereby authorize Milan L. Hopkins, M.D. to disclose and verify my medical records to law enforcement should I be arrested or detained related to my possession or use of marijuana. I understand that Milan L. Hopkins, M.D. will only provide verification of my patient status for the purpose of providing proof to justify my possession of marijuana. I understand that this authorization is valid for the period of time for which the recommendation for marijuana had been issued by Milan L. Hopkins, M.D.

Patient Signature: ____ Date: ______________________

Patient Name Printed: ____

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INFORMED CONSENT

(Please initial each item)

I am being evaluated for a physician's recommendation for the medicinal use of 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:

(*initials*)

1. ______ 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 California, which have modified their state laws to treat marijuana as a medicine.
2. ______ 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.
3. ______ 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."
4. ______ 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 cause me to talk or eat in excess, alter my perception of time and space and impair my judgement. Many medical authorities claim that use of marijuana, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, a tendency

to drug abuse, and schizophrenia. Milan L. Hopkins, M.D. recommends marijuana use only for the relief of serious symptoms, and not for habitual use.

5. _____ 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. Cannabis should be treated as an open container of alcohol. It should not be within reach in the car, and should not be extinguished in the vehicles ash tray.
6. ______ I agree to contact Milan L. Hopkins, M.D. 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 Milan L. Hopkins, M.D. if I experience respiratory problems, changes in normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.
7. ______ 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.
8. ______ 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).
9. ______ 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 of if I think that I may be developing a dependency on marijuana, I should contact Milan L. Hopkins, M.D.
10. ______ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances, and unusual tiredness.
11. ______ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in hands, feet, arms or legs, anxiety attacks, and incapacitation. If I experience these symptoms, I agree to contact Milan L. Hopkins, M.D. immediately or go to the nearest emergency room.
12. ______ If Milan L. Hopkins, M.D. 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 Milan L. Hopkins, M.D. and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.
13. ______ I have had the opportunity to discuss these matters with the physician and to ask any questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Milan L. Hopkins, M.D. has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. Milan L. Hopkins, M.D. also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that Milan L. Hopkins, M.D. informed me of any alternatives to the recommended treatment, including the alternative of no treatment and the risks and benefits.

14. ______ Quantity specifications are located on the recommendation. Gardens should have and embossed recommendation prominently posted at all entrances. It may be helpful to post signs with a red cross around the garden, indicating that the plants are for medical purposes. Embossed copies can be made for 25 cents a copy.
15. ______ When under the influence and/or in possession of cannabis in public, a copy of your recommendation should be on your person at all times.
16. ______ I acknowledge that if I, the patient, am issued a citation, arrested, and/or if Milan L. Hopkins, M.D. receives a subpoena related to my marijuana recommendation, I will be required to pay a $250.00 legal deposit within 10 days of receiving the citation, being arrested, and/or Milan L. Hopkins, M.D. receiving a subpoena. Failure to pay within 10 days will result in being discharged as a patient.
17. ______ In order to stay in compliance with the California State Medical Board regulations, it is required that you return to your recommending physician for a review of you medical condition and to update your recommendation **every six months.** **If you are overdue for your visit you will be charged an additional fee of $50.00.** Extensions can be given for personal emergencies or special circumstances. An outdated recommendation may place the Doctor's Medical License in jeopardy with the Medical Board, and the patient is at risk of being issued a citation and/or arrested. If such an incidence occurs, we require a deposit of $250.00 for any services rendered by Milan L. Hopkins, M.D. If you are unable to pay said amount at the time of appointment, a temporary recommendation will be issued.
18. **______ Patients giving any dishonest or untruthful information will be discharged.**

Patient Signature: ____ Date: _________________________

Patient Name Printed: ____

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Acknowledgement Review

of

Notice of Privacy Practices

I hereby acknowledge that I have been made aware of the Notice of Privacy Practices for Milan L. Hopkins, M.D. I understand that I may obtain additional copies upon request, as described in the notice.

This acknowledgement will be filed with my records.

Patient Signature: ____ Date: ________________________

Patient Name Printed: ____

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Medical Marijuana Amounts

Any patient growing more than six mature plants is at risk of prosecution regardless of the amount specified on the recommendation. The patient is allowed a defense of medical necessity. This entails evidence of the need for larger amounts than six plants. Since I do not make any determination of the individual amounts, neither the recommendation nor the medical record will provide this evidence. If you will be growing more than allowed, I strongly advise that you proactively document your need for increased amounts. An excellent guide to this documentation is *Cannabis Yields and Dosage* by Chris Conrad, printed by Creative Expressions in El Cerrito. You can find it online at: http://www.chrisconrad.com/pdf/cannayieldsdosage10.pdf

This advice is the result of my experience as a physician, as I am not qualified to give legal advice.

Patient Signature: ____ Date: ______________________