

Robert F. Sterner, M.D.
(619) 543-1061

Please answer these questions to the best of your ability and use additional paper if needed, thank you.

Patient Name: _____ **Date:** _____

1. Do you have current medical records on your medical condition and/or history? (If no, why?): _____

2. What are your current health concerns and/or complaints?: _____

3. Do you have painful muscles or general aches pain? (If yes, please explain): _____

4. What, if any, are the tasks performed, or specific times of the day, your pain seems to intensify?: _____

5. How do you feel about yourself? (self-esteem, mental health, general health): _____

6. What medications are you currently taking?: _____

7. Do you feel the medication(s) are effective? What are some, if any, side effects?: _____

8. List your history of medications and/or drugs you have taken and why you discontinued: _____

9. What reasons do you feel medical cannabis has helped (or can help) with your medical condition?:

10. Have you ever tried Marinol (a synthetic substitute for marijuana)?: _____

11. Are you aware of risks and or side effects with medical cannabis? (If yes, please list): _____

12. Are you aware of the legalities involved with medical cannabis? (If no, please obtain informational consent from Dr. Sterner's office): _____

13. How often do you visit with your primary care physician or original treating physician?: _____

14. Have you been informed and/or do you understand the California Health and Safety Code, Section 11362.5, i.e., Compassionate Use Act of 1996, or Proposition 215?:

15. Please use these lines or, the back, if needed, to ask any questions or add comments you may have:

Patient Signature: _____ Date: _____

Patient Name: _____ Physician's initials: _____
(Print name)