SOLEVO WELLNESS

**SOLEVO WELLNESS DEMOGRAPHIC FORM**

**Today's Date:** _____

**Patient Name:** _____ ☐ Jr. ☐ Sr.
*First* *Middle* *Last*

**Date of Birth**: ____/____/____ **Age**:____ **Race/Ethnicity**: ☐ Caucasian ☐ Black ☐ Asian ☐ Other

**Address**: _____
Street

_____
City State Zip

**Primary Phone:** (_____)_____-_____☐ Home ☐ Cellular ☐ Work

**Secondary Phone:** (_____)_____-_____☐ Home ☐ Cellular ☐ Work

**Email:** _____

**Preferred Method of Contact (please circle): A. Voice B. Email C. Text**

**May we leave personal medical information on your primary or secondary phone #**? ☐ **YES** ☐ **NO**

**Driver's License Number/Identification Card Number_____ Expiration Date_____**

**Medical Marijuana ID Issue Date_____ Expiration Date_____**

## YOUR HEALTH CARE TEAM

**Name/Specialty of Physician Recommending to Solevo Wellness**: _____

Telephone#: (_____)_____-_____ Facility Address:_____

**Please list any other health care providers for Solevo Wellness to send clinical updates:**

Name: _____Specialty: _____

Phone#: (_____)_____-_____ Facility Address:_____

Name: _____Specialty: _____

Phone#: (_____)_____-_____ Facility Address:_____

**SOLEVO WELLNESS PATIENT DEMOGRAPHIC FORM CONT… Name:_____**

**Do you give permission to discuss your medical information with family or other caregiver? □ NO □YES**
**If yes, please provide the name and phone number below:**

Name: _____Relationship: _____

Phone#: (_____)_____-_____

## MEDICAL HISTORY

**Do you have any of the following medical conditions:**

| | | | | | |
|---|---|---|---|---|---|
| Amyotrophic Lateral Sclerosis | **YES** | **NO** | Huntington's Disease | **YES** | **NO** |
| Autism | **YES** | **NO** | Inflammatory Bowel Disease | **YES** | **NO** |
| Cancer (if yes, what kind) | **YES** | **NO** | Intractable Seizures | **YES** | **NO** |
| _____ | | | Multiple Sclerosis | **YES** | **NO** |
| Autoimmune condition | | | | | |
| Crohn's Disease | **YES** | **NO** | Neuropathies | **YES** | **NO** |
| Spinal Cord Injury/Spasticity | **YES** | **NO** | Parkinson's Disease | **YES** | **NO** |
| Epilepsy | **YES** | **NO** | Post-Traumatic Stress Disorder | **YES** | **NO** |
| Glaucoma | **YES** | **NO** | Severe Chronic Pain | **YES** | **NO** |
| HIV/AIDS | **YES** | **NO** | Sickle Cell Anemia | **YES** | **NO** |
| | | | Other_____ | **YES** | **NO** |

**Please list other medical conditions not listed above**:_____

_____

**Surgical History:** _____

**Do you have, or is there any family history of schizophrenia/mental illness?** †YES † NO

**(Females) Are you pregnant?:** †YES † NO **(Females) Are you trying to become pregnant?:** YES † NO

**Medical Marijuana History**:

**Have you ever used medical marijuana? †YES †NO If yes, what form _____**

**Social History:** Do you smoke? †**NO** †**YES**___ __ pack/cig per day Do you smoke tobacco? †**YES** **NO** _____ per day

Do you drink alcohol? †**NO** †**YES**___ __ drinks per day

**MEDICATIONS: Please list prescription and over-the-counter medications you are CURRENTLY taking:**

_____ _____

_____ _____

_____ _____

**Favorite Product(Optional)**

1._____

2._____

3._____

**How did you hear about us?**

- ❑ Leafly
- ❑ Weedmaps
- ❑ Google
- ❑ Stickyguide
- ❑ Billboard Sign
- ❑ Bus Shelter
- ❑ Friend/Patient
- ❑ Post-Gazette
- ❑ WTAE
- ❑ KDKA
- ❑ NPR
- ❑ Pittsburgh City Paper
- ❑ HighTimes
- ❑ Facebook
- ❑ Instagram
- ❑ Other_____

**OFFICE USE ONLY**

Pharmacist Signature_____ Date_____

Recommendation: