OMMP MEDICAL DOCUMENTATION FORM

Exam Date:	Attending Physician:

PATIENT INFORMATION

Patient Name:	DOB:	Male ☐ Female ☐

Debilitating Condition:	

REVIEW OF PATIENT'S MEDICAL HISTORY

Review of medical history completed: Yes ☐ No ☐	Date Reviewed:

Other Medical Conditions:	
Medications:	
Allergies:	

PHYSICAL EXAM

Height:	Weight:	Temp.:
Pulse:	Respirations:	B/P:
General Appearance: Good ☐ Fair ☐ Poor ☐		

HEENT:	
Neurological:	
Skeletal/Extremities (Musculoskeletal):	
Back/Spine:	
Lung/Chest:	
Abdomen/Gastrointestinal:	
Mental Health:	

COMMENTS/NOTES

TREATMENT PLAN & FOLLOW UP

☐ The risks and benefits of medical marijuana have been explained to the patient.

☐ Patient provided with medical cannabis information.

Follow up appointment in: _____ months. **Patient should:** ☐ Return to clinic; ☐ See primary care physician; ☐ Other:

ATTENDING PHYSICIAN SIGNATURE

Signature:	Date:
Printed Name:	