

OMMP MEDICAL DOCUMENTATION FORM

Exam Date:	Attending Physician:
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PATIENT INFORMATION

Patient Name:	DOB:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Debilitating Condition:			

REVIEW OF PATIENT'S MEDICAL HISTORY

Review of medical history completed: Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date Reviewed:
Other Medical Conditions:		
Medications:		
Allergies:		

PHYSICAL EXAM

Height:	Weight:	Temp.:
Pulse:	Respirations:	B/P:
General Appearance: Good <input type="checkbox"/>		

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

COMMENTS/NOTES

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TREATMENT PLAN & FOLLOW UP

<input type="checkbox"/> The risks and benefits of medical marijuana have been explained to the patient.
<input type="checkbox"/> Patient provided with medical cannabis information.
Follow up appointment in: _____ months. Patient should: <input type="checkbox"/> Return to clinic; <input type="checkbox"/> See primary care physician;
<input type="checkbox"/> Other:

ATTENDING PHYSICIAN SIGNATURE

Signature:	Date:
Printed Name:	