HEATHER KRANTZ, M.D.

CONSENT & HEALTH HISTORY—Page 1

Last Name:_____First Name:_____MI:_____

Date of Birth:_____Age:_____Gender:M_____F_____Other_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Alternate Phone:_____

E-Mail:_____

Emergency Contact:_____Phone:_____Relationship:_____

Where did you here about us?_____

CONSENT/Release of Liability

I affirm that I have a serious medical condition that adversely affects my quality of life. I am interested in using medical marijuana (cannabis) for relief and/or improvement of my condition.

I understand that cannabis is not regulated by the U.S. Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities, and/or contaminants. In requesting a permit for the use of cannabis as medication, I assume full responsibility for any and all risks of this action.

I am advised that cannabis smoke contains chemicals that may be harmful to my health. Unknown chemicals may be present in vaporized cannabis as well. Should respiratory problems or other ill effects be experienced with its use, cannabis should be discontinued and the symptoms reported to the physician.

I am advised that the use of cannabis may affect my coordination and cognition in ways that could impair my ability to drive, operate heavy machinery, or engage in potentially hazardous activities. There may be other risks not addressed herein. I assume full responsibility for any harm to me and/or other individuals as a result of my use of cannabis.

Oregon state medical marijuana law provides for the possession and cultivation of cannabis for the personal medical purposes of the patient, with a physician statement. The physician, staff, and representatives of this practice are neither providing cannabis, nor are they encouraging any illegal activity in obtaining cannabis.

I, the undersigned, hereby request a consultation with the physician for the purposes of determining the appropriateness of medical cannabis treatment for myself. The physician, staff, and representatives are addressing specific aspects of my medical care and are in no way establishing themselves as the primary care provider. Should my medical use of cannabis be approved, I understand there is a renewal date specified. I understand that it is my responsibility to see the physician to assess the possible continuance of medical cannabis use beyond the term of approval. Furthermore, the undersigned, my heirs, assigns or anyone acting on my behalf, hold the physician and his/her principals, agents, and employees free of and harmless from any liability resulting from my use of cannabis.

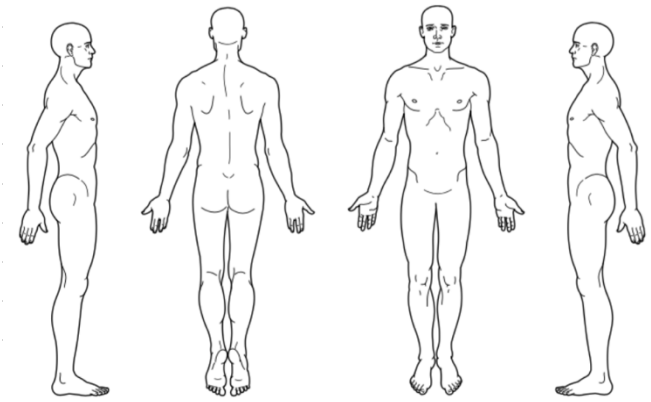
I hereby authorize Heather Krantz, M.D. and her representatives to confirm my status as a current patient when requested to do so by law enforcement or patient service organizations.

Signature:_____Date:_____

HEATHER KRANTZ, M.D.

HEALTH HISTORY—Page 2

On the diagram below, mark areas where you feel pain.



Primary Medical Complaint:_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies:_____

_____

Past Medical History:

- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Breast disease/lesions
- ☐ Diabetes
- ☐ Back or neck pain
- ☐ Cachexia
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Prostate disease
- ☐ Blood disorders
- ☐ Substance abuse
- ☐ Other:_____

- ☐ Cancer, specify:_____
- ☐ Chronic pain, specify:_____
- ☐ Brain disorders (epilepsy, trauma, etc.)
- ☐ Dystonia (spasms, tremors, Parkinson's)
- ☐ Kidney disorders
- ☐ Liver disease (cirrhosis, hepatitis B or C)
- ☐ Lung disease (asthma, emphysema)
- ☐ Mental disorders (depression, anxiety)
- ☐ Ear problems (tinnitus, hearing loss)
- ☐ Eye problems (glaucoma, cataracts)
- ☐ Weight loss/gain

- ☐ Intestinal (colitis, IBS, ulcers)
- ☐ Shingles (herpes zoster)
- ☐ Circulation (stroke, phlebitis)
- ☐ Eating disorder
- ☐ Rheumatic disease (lupus)
- ☐ Endocrine (thyroid, hormone)
- ☐ Genital/gyn problems
- ☐ Skin (psoriasis, eczema)
- ☐ Sleep disorders
- ☐ Heart disease
- ☐ PTSD

Please list all current medications:_____

_____

_____

_____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I have received or reviewed a copy of the Notice of Privacy Practices from this practice.

_____ _____

Patient name (print) Name of authorized representative (if applicable)

_____ _____

Patient signature (or authorized representative) Date