# MMJ EXAMS OF COLORADO

NAME:___________________________________________

___Married ___Single ___Divorced ___Widowed ______# of Children – Ages ____ ____ ____ ____ ____

**MEDICATIONS:** _________________________ _______________________ ______________________

_________________________ _______________________ ______________________

_________________________ _______________________ ______________________

**REVIEW OF SYSTEMS**

Have You Had problems with any of the following organs or organ systems?

| | YES | NO | |
|---|---|---|---|
| HEAD: | ____ | ____ | Brain Aneurysm, Severe Headache, Other_________________________________ |
| EYES: | ____ | ____ | Glaucoma, Cataracts, Blurred Vision, Blindness, Other ______________________ |
| EARS: | ____ | ____ | Deafness, Hearing loss, Vertigo, Ringing in Ears, Other______________________ |
| NOSE: | ____ | ____ | Sinus Infections, Nose Bleeds, Nasal Congestion,Other ______________________ |
| THROAT: | ____ | ____ | Mouth Sores, Sore Throat, Sore Tongue, Other____________________________ |
| CHEST: | ____ | ____ | COPD, Cough, Asthma, Emphysema, Pneumonia, TB, Other__________________ |
| HEART: | ____ | ____ | Heart Attack, Angina, Heart Failure, Heart Murmer, Other___________________ |
| ABDOMEN: | ____ | ____ | Liver Disease, Hepatitis, Pancreatitis, Gallstones, Other_____________________ |
| GI: | ____ | ____ | Nausea, Reflux, Hiatal Hernia, Ulcer, Chronic Diarrhea,Other_________________ |
| URINARY: | ____ | ____ | Kidney Stones, Kidney Disease, Urethritis, Other__________________________ |
| INFECTIONS | ____ | ____ | Aids, Hepatitis, Herpes, Other________________________________________ |
| SKELETAL | ____ | ____ | Arthritis, Pain in Joints, Pain in Muscles, Other___________________________ |
| HEMATOL: | ____ | ____ | Bleeding Disorder, Swollen Glands (lymph nodes), Other ___________________ |
| SKIN: | ____ | ____ | Skin Cancer, Seborrhea, Psoriasis, Other _________________________________ |
| VASCULAR: | ____ | ____ | High Blood Pressure, Blood Clots, Emboli, High Cholesterol, Other____________ |
| ENDOCRIN: | ____ | ____ | Diabetes, Thyroid Disease, Pituitary Disease, Other Hormonal Problems _________ |
| NEURO: | ____ | ____ | Stroke, Numbness, Tremor, Seizures, Dizziness, Other ______________________ |
| PSYCH: | ____ | ____ | Psychological Disease, ______________________________________________ |

**CANCER** ____ ____ Date___________ Type______________________________ Remission ___Y___N

____ ____ Date___________ Type______________________________ Remission ___Y___N

**HABITS**

| | | | | |
|---|---|---|---|---|
| Smoke | ____ | ____ | #Pks/day_____ | How Long?_______________ |
| Coffee/Caffeine | ____ | ____ | What?____________________ | How Much_________________ |
| Alcohol? | ____ | ____ | What?____________________ | How Much?________________ |
| Drug Abuse | ____ | ____ | What?____________________________________________________ | |

**SURGICAL HISTORY**

| | Date | Surgery | Date | Surgery |
|---|---|---|---|---|
| SURGERY | _________ | __________________________ | _________ | _________________________ |
| SURGERY | _________ | __________________________ | _________ | _________________________ |

**FAMILY HISTORY**

| | Age | Medical Problems (If Deceased, put age and cause of death) |
|---|---|---|
| FATHER | ____ | ______________________________________________________ |
| | | ______________________________________________________ |
| MOTHER | ____ | ______________________________________________________ |
| | | ______________________________________________________ |
| CHILDREN | ____ | ______________________________________________________ |
| | ____ | ______________________________________________________ |
| | ____ | ______________________________________________________ |