Name: Date:

Address: Doctor's Name:

City: Prov.: Referred by:

Telephone #: Occupation: D.O.B.:

Medical Cannabis Assessment

Chief Problem for Which Cannabis Is Being Requested: _____

What year did the problems start? _____(year)

What can you do **physically** that makes the symptoms worse?

What can you do **physically** to feel better? (if anything)

Are there any secondary medical problems? No Yes (circle one)

If Yes, please list the diagnoses:

Do you currently use marijuana for relief? No YES - smoke, vapour, edible?

If YES above, how many times a day do you use it? _____

When did you last use it? _____ How long have you used it **medically**?_____

If Yes, do you obtain it non-legally from a street source? No Yes

If you do not obtain a prescription for marijuana, will you continue to use it? No Yes.

Do you smoke tobacco? No Yes - cigarettes, cigars, pipe- number per day._____

Do you drink alcohol? No Yes - beer, wine or spirits - how much per week? _____

Do you use medicines containing opiates? (Codeine, morphine, other) No Yes

If Yes, which ones do you use, how often and what dosage? _____

Do you use cocaine or other "street" drugs? No Yes If Yes, which ones do you use and how often? _____

Are you allergic to any medicine? No Yes

If Yes, please list the medications you are allergic to:

Family History:

Is your father alive? No. Yes. In good health? If "No" - cause of death

Is your mother alive? No. Yes. In good health? If "No" - cause of death

Do you have siblings? No. Yes. (Please list ages, genders and states of health)

Do any of your family members suffer from psychiatric disorders? No Yes.

Medications: (please list your current prescription medications, the doses and times taken)

(provide list printed at medical pharmacy)

Please list any medications that have **FAILED** to work for you:

Social history: single, married, divorced, other (please circle one).

Dwelling: house, apartment, shared space, institution, no fixed address (please circle one).

Who lives with you? (Wife, husband, partner, no one) (please circle one).

If children are in your dwelling, please list them and their ages:

History of Operations-Surgeries: (please list any surgery you have had and the year)

Psychological History: (please circle diagnosis below)

Do you suffer from: Anxiety Depression Insomnia Bipolar disorder OCD.

What year did the condition begin? _____.

Have you been hospitalized for any of these? No Yes (what year)_____.

Have you had any thoughts of self-harm or suicide? No Yes.

Review of Systems

Do you have any problems with senses (smell, taste, sight, hearing or touch)? No Yes.

Do you have any problems with your head or neck? No Yes.

Do you have any problems with breathing or lung diseases? No Yes.

Do you have heart or circulation problems? No Yes.

Do you have problems climbing stairs or exercising? No Yes.

Do you have any eating, swallowing, digestion or problems with bowels? No Yes.

Do you have any problems with your kidneys, bladder or urination? No Yes.

Pregnancy: are you pregnant now or might you become pregnant in the near future? No Yes.

Do you have problems with your muscles or joints? No Yes.

If yes, please indicate which joints or muscles are bothering you.

General: Height: Weight:

Are you in any distress now? No Yes.

If Yes, please describe.

Do you feel comfortable now? No Yes.

Are you aware of the date, time and current location? No Yes.

Are you often confused? No Yes.

If you drive a vehicle on the road or operate machinery, do NOT do so:

1. Within 4 (FOUR) hours of inhaling cannabis vapour or smoke,

2 Within 6 (SIX) hours of eating or ingesting cannabis edibles or oil,

3. Within 8 (EIGHT) hours of using, if you get euphoric or dizzy - "Stoned"

Remember to keep all cannabis products, and medicines, in a Locked Box.

Signature of patient: _____

Assess:

Plan: