Medicinal Cannabis follow up and Adverse Effects Assessment Questionnaire

Patient Information:

- Name: Tharindu Hettiarachchi
- Date of Birth: 2024-01-01
- Date of Assessment: 2024-01-01
- Healthcare Provider: Healthcare Provider

Instructions: Please answer the following questionsto the best of your ability. Be honest and specific about any symptoms or experiences you've had since starting medicinal cannabis treatment.

Section 1: Baseline Information

1. **Diagnosis/Condition Requiring Medicinal Cannabis:** Test
2. **Date Started Medicinal Cannabis Treatment:** 2024-01-02
3. **Cannabis-Based Product Name (if known):** Test
4. **On a scale of 1-5 (1 the least 5 the most), how much improvement has there been of your medical condition?** 5

Section 2: Adverse Effects Assessment

Please mark the appropriate box for each item below:

(Use a scale from 0 to 3, where 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe)

Adverse Effect	Severity (0-3)	Onset Date	Description (if any)
Nausea	1	01/16/2024	Description
Vomiting	2	01/03/2024	Description
Dizziness	3	01/12/2024	Description
Dry Mouth	0	01/14/2024	Description
Fatigue	3	01/07/2024	Description
Sleep Disturbances	2	01/03/2024	Description
Mood Changes			
Anxiety			
Confusion			
Headaches			
Memory Impairment			
Increased Heart Rate			
Coordination Problems			
Gastrointestinal Problems			
Other (specify)			

Section 3: Impact on Daily Life

- **Please describe how the adverse effects have affected your daily life, including work, social activities, and personal well-being.** Tets

Section 4: Additional Comments

- **Do you have any other comments or concerns about your experience with medicinal cannabis treatment and its adverse effects?** Test

Section 5: Follow-up and Recommendations

- **Based on your responses and our discussion, we may need to make adjustments to your treatment plan. Please check the appropriate box as to what you would prefer:** Continue current treatment.