

Medicinal Cannabis follow up and Adverse Effects Assessment Questionnaire

Patient Information:

- Name: test
- Date of Birth: 1970-02-06
- Date of Assessment: 2024-01-30
- Healthcare Provider: testing.....

Instructions: Please answer the following questions to 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:** headaches
2. **Date Started Medicinal Cannabis Treatment:** 2024-01-04
3. **Cannabis-Based Product Name (if known):** tes
4. **On a scale of 1-5 (1 the least 5 the most), how much improvement has there been of your medical condition?** 4

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	01/11/2024	
Vomiting	2	01/24/2024	
Dizziness	3	01/09/2024	
Dry Mouth	1	01/03/2024	
Fatigue	3	01/17/2024	
Sleep Disturbances	2	01/18/2024	
Mood Changes	1	01/05/2024	
Anxiety	2	01/07/2024	
Confusion	3		
Headaches	1	01/05/2024	
Memory Impairment	3	01/08/2024	
Increased Heart Rate	2	01/04/2024	
Coordination Problems	3	01/10/2024	
Gastrointestinal Problems	2	01/11/2024	
Other (specify)	1	01/05/2024	

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.** test

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.