Medicinal Cannabis follow up and Adverse Effects Assessment Questionnaire

MARUCANNA

Conducted by : Dr. Test Doctor

Confidential Document

Patient Information:

- Name: Peter Alfred Smith
- Date of Birth: 1988-10-03
- Date of Assessment: 2024-03-14
- Healthcare Provider: test 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:** DIAGNOSIS/CONDITION REQUIRING MEDICINAL CANNABIS
2. **Date Started Medicinal Cannabis Treatment:** 2024-03-01
3. **Cannabis-Based Product Name (if known):** CANNABIS-BASED PRODUCT NAME (IF KNOWN)
4. **On a scale of 1-5 (1 the least 5 the most), how much improvement has there been of your medical condition?** ON A SCALE OF 1-5 (1 THE LEAST 5 THE MOST), HOW MUCH IMPROVEMENT HAS THERE BEEN OF YOUR MEDICAL CONDITION?

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	03/16/2024	test
Vomiting	2	03/07/2024	test
Dizziness	3	03/06/2024	test
Dry Mouth	4	03/02/2024	test
Fatigue	10	03/03/2024	test
Sleep Disturbances	1	03/07/2024	test

Adverse Effect	Severity (0-3)	Onset Date	Description (if any)
Mood Changes	2	03/02/2024	test
Anxiety	3	03/04/2024	test
Confusion	2	03/02/2024	test
Headaches	3	03/07/2024	test
Memory Impairment	3	03/14/2024	test
Increased Heart Rate	1	03/03/2024	test
Coordination Problems	3	03/20/2024	test
Gastrointestinal Problems	2	03/01/2024	test
Other (specify)	3	03/02/2024	test

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.** PLEASE DESCRIBE HOW THE ADVERSE EFFECTS HAVE AFFECTED YOUR DAILY LIFE, INCLUDING WORK, SOCIAL ACTIVITIES, AND PERSONAL WELL-BEING.

Section 4: Additional Comments

- **Do you have any other comments or concerns about your experience with medicinal cannabis treatment and its adverse effects?** DO YOU HAVE ANY OTHER COMMENTS OR CONCERNS ABOUT YOUR EXPERIENCE WITH MEDICINAL CANNABIS TREATMENT AND ITS ADVERSE EFFECTS?

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.