



Medical ID Number _____ Expiration Date _____

Height _____ Weight _____ Gender _____ Date of Birth _____ Age _____

Email Address _____

Daytime Phone _____ Home Work Cell _____ Evening Phone _____ Home Work Cell _____

Physician _____ Physician's Address _____

Physician's Practice _____ Physician's Phone _____

Emergency Contact _____ Contact's Phone _____ Relationship _____

Caregiver _____ Caregiver's Phone _____

Qualifying Diagnosis _____

I am using cannabis to relieve the symptoms of one or more of the following debilitating medical conditions:

- | | | | |
|--------------------|----------------|--------------------|---------------|
| AIDS | Asthma | Anxiety | Arthritis |
| Cachexia | Cancer | Convulsions | Epilepsy |
| Glaucoma | HIV | Migraines | Muscle Spasms |
| Severe Nausea | Severe Pain | Muscular Dystrophy | Seizures |
| Multiple Sclerosis | Sleep Disorder | Others: _____ | |

Which of the following symptoms are related to your medical conditions?

- | | | | |
|---------------|---------------------|--------------|---------|
| Poor appetite | Shortness of breath | Restlessness | Pain |
| Irritability | Cramps | Insomnia | Fatigue |
| Anxiety | Depression | Stress | Spasms |
| Nausea | Others: _____ | | |

On a scale of 1 - 5, how important to you are the following potential positive side effects of cannabis?

Appetite	Not Important	1	2	3	4	5	Very Important
Relaxation	Not Important	1	2	3	4	5	Very Important
Pain Relief	Not Important	1	2	3	4	5	Very Important
Stimulation	Not Important	1	2	3	4	5	Very Important
Psychoactivity	Not Important	1	2	3	4	5	Very Important



Have you previously used cannabis to treat your condition? Yes No

If yes, for how long? Please describe your routine for self-medication. Has this routine varied over the time of treatment?

In your assessment, is cannabis effective in treating your condition? Yes No

How do you compare cannabis use to other medications you have used to alleviate your symptoms?

Less Effective Same More Effective

What is your preferred method of cannabis consumption?

Inhalation (smoking/vaporizing):	Cured Flower	Concentrates	
Sublingual:	Tinctures	Glycerites	Lozenges
Ingestion:	Baked Goods	Capsules	Beverages
Topical (transdermal/local):	Patches	Gels/Lotions	Salves

How involved is your physician in managing your use of cannabis to treat your symptoms?

Not at all Very Little Moderately Completely



Do you have any known allergies or dietary sensitivities?

Yes

No

If yes, please provide details here:

Please use this area to share any other information that would help us understand your medicinal needs:

Text
