# FLORIDA COMPASSIONATE CARE CENTERS, LLC

PATIENT RECERTIFICATION

Date: ________________________

_____________________________________________________________________________________

First Name Middle Name Last Name

DOB: ___________________________

MM/DD/YYYY

What is the main reason you are being seen today? _________________________________________

What is the condition(s) you are using Medical Marijuana for?

_____________________________________________________________________________________

Are there any medications you have been able to stop or reduce using since using Medical Marijuana?
_____Yes _____No

Pain Level (Circle One): 1 2 3 4 5 6 7 8 9 10

Pain is (Circle all that apply): Sharp Dull Constant Intermittent

Current Pain Medications – Please include your Medical Marijuana or Low-THC:

_____________________________________________________________________________________

Adverse Reactions (circle all that apply):

None Vomiting Confusion Dizziness Fatigue Constipation Diarrhea Sleeplessness

Other: _________________________________________

Since the last visit to FCCC, how much relief has the Medical Marijuana treatment and medication provided (Please circle one answer below)?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Are you comfortable with the current dosing of your medication? Yes No

_____________________________________________________________________________________

If no what adjustments would you like? __________________________________________________