FOLLOW UP AND RECERTIFICATION VISIT QUESTIONNAIRE

1. NAME: _____ DATE: _____

2. LIST ALL CHANGES TO YOUR MEDICATIONS SINCE YOUR LAST VISIT: NONE _____

_____

3. LIST ALL NEW PHYSICIANS THAT YOU ARE SEEING SINCE YOUR LAST VISIT: NONE _____

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

4. LIST ALL ADDITIONAL PROCEDURES THAT YOU HAD SINCE YOUR LAST VISIT: NONE _____

_____

_____

5. PLEASE LIST THE CANNABIS PRODUCT(S) THAT YOU USED AND DESCRIBE YOUR EXPERIENCE(S):

Products purchased and tried (product/route)	Did they help to achieve your goals	Side effects or unwanted effects	Effects on your other medications
A.			
B.			
C.			
D.			

6. If goals were achieved or you had unintended benefits, please describe how cannabis helped: _____

_____

_____

7. If your goals were not achieved, did you increase your dose? _____ Yes _____ No

8. How did you address any unwanted effects: _____

_____

9. Did you respond better to any particular route of administration? If so, how? _____

_____

10. How has medical marijuana affected your:

a) Pain Levels: Before Use (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High NA _____

After Use (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High

b) Anxiety Levels: Before Use (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High NA _____

After Use (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High

c) Depression Levels: Before Use (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High NA _____

After Use (Circle one) Low 1 2 3 4 5 6 7 8 9 10 High