CANNABIMED
Medical Marijuana Certification

Patient Questionnaire

Name: _____ Date: _____

DOB: _____ SS #: _____ Driver Lic: _____

Address: _____

County: _____ Height: _____ Weight: _____

Phone #: _____ Email: _____

Primary Care Doctor: _____ Phone #: _____

Please list all medical conditions:

1: _____ 2: _____

3: _____ 4: _____

5: _____ 6: _____

7: _____ 8: _____

Please list all medications you are currently taking:

1: _____ 2: _____

3: _____ 4: _____

5: _____ 6: _____

7: _____ 8: _____

Do you Smoke: Yes / No How many per day: _____ For how long: _____

Do you drink Alcohol: Yes / No How many drinks per week: _____ For how long: _____

Do you use any drugs: Yes / No What type: _____ How often: _____

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Reason for seeking Medical Marijuana (Please circle one)

Cancer Epilepsy Glaucoma HIV AIDS Multiple Sclerosis

Post Traumatic Stress Disorder (PTSD) Amyotrophic lateral sclerosis Crohn's disease

Parkinson's disease Chronic Pain Any Terminal Condition Anxiety Depression

Seizures Severe Nausea Ulcerative Colitis Anorexia Bulimia

Other: _____

Please explain for how long you have had this medical condition, what symptoms are you experiencing and how severe are your symptoms:

_____
_____
_____
_____
_____
_____
_____

Please list any treatments you are receiving now or have received for your medical condition:

_____
_____
_____
_____
_____
_____
_____

Patient signature: _____ Date: _____

Caregiver signature: _____ Relation to patient: _____