



Medical Cannabis Patient Questionnaire

Personal Information

- **Full Name:** _____
- **Date of Birth (DD/MM/YYYY):** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Address:** _____

Medical History

1. **What medical condition(s) are you seeking cannabis treatment for?**

- Chronic Pain
- Anxiety
- PTSD
- Epilepsy/Seizures
- Cancer-related symptoms
- Multiple Sclerosis
- Sleep Disorders
- Other (please specify): _____

2. **How long have you been experiencing these condition(s)?**

3. **List all current medications and treatments you are using:**

4. **Have you used cannabis before?**

- Yes
- No

If yes, please describe (e.g., method, dosage, effects):

5. **Have you had any adverse reactions to cannabis?**

- Yes
- No

If yes, please explain:

6. **Do you have a history of mental health conditions? (e.g., schizophrenia, bipolar disorder)**

- Yes
- No

If yes, please describe:

Lifestyle Information

7. **Do you consume alcohol?**

- Yes
- No

If yes, how many drinks per day/week _____

8. **Do you smoke tobacco or vape nicotine?**

- Yes
- No

9. **Are you currently pregnant, breastfeeding, or planning to become pregnant?**

- Yes
- No
- Not applicable

Treatment Goals

10. **What symptoms are you hoping to alleviate with medical cannabis?**

- Pain
- Anxiety
- Nausea
- Insomnia
- Muscle Spasms
- Appetite Loss
- Other (please specify): _____

11. **Preferred method of cannabis administration (if any):**

- Smoking
- Vaporizing
- Edibles
- Oils/Tinctures
- Topicals
- Capsules
- No preference

Additional Information

12. Any allergies (especially to medications, plants, or foods)?

13. List here any current medical conditions:
