DrShahabSojoudi
GENERAL PRACTITIONER

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)?**

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

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4. **Have you used cannabis before?**
   ☐ Yes
   ☐ No

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

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5. **Have you had any adverse reactions to cannabis?**
   ☐ Yes
   ☐ No

If yes, please explain:

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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)?**

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13. **List here any current medical conditions:**
