# PATIENT PERSONAL INFORMATION

| Full Name: | DOB (MM/DD/YYYY): | Gender: |
|---|---|---|
| Residency Address: | City: | Province: |
| Postal Code: | Phone # you can be reached: | E-mail Address: |

# MEDICAL HISTORY

**Check mark ✔ in the appropriate box**

| **Have you been assessed and diagnosed by a Family Physician/Specialist/s with an eligible Medical Condition/s to access cannabis for medical purposes?** | ☐ Yes ☐ No |
|---|---|

**What is the Dominant/Main Diagnosed Medical Condition that you would like to be treated with cannabis?**

| | | |
|---|---|---|
| ☐ **Chronic Pain interfering with functioning**<br>☐ Severe Neuropathic pain<br>☐ Chronic non-Cancer pain<br>☐ Severe refractory Cancer-associated pain<br>☐ Headache<br>☐ Migraine<br>☐ **Multiple Sclerosis (MS)**<br>☐ **Amyotrophic Lateral Sclerosis (ALS)**<br>☐ **Spinal Cord Injury**<br>☐ **Spinal Cord Disease**<br>☐ **Epilepsy (Seizures)**<br>☐ **Alzheimer's Disease**<br>☐ **Dementia**<br>☐ **Movement Disorders**<br>☐ Cervical Dystonia/Spasmodic<br>☐ Torticollis<br>☐ Huntington's Disease<br>☐ Parkinson's Disease<br>☐ Tourette's Syndrome | ☐ **Arthritis, Musculoskeletal Disorders**<br>☐ Osteoarthritis<br>☐ Rheumatoid Arthritis<br>☐ Fibromyalgia<br>☐ Osteoporosis<br>☐ **Inclusion Body Myositis (IBM)**<br>☐ **Asthma**<br>☐ **Glaucoma**<br>☐ **Hypertension**<br>☐ **Gastrointestinal System Disorders**<br>☐ Irritable Bowel Syndrome<br>☐ Inflammatory Bowel Diseases<br>☐ Ulcerative Colitis<br>☐ Crohn's Disease<br>☐ Hepatitis<br>☐ Pancreatitis<br>☐ **Metabolic Syndrome/Obesity**<br>☐ **Severe refractory nausea and vomiting associated with cancer chemotherapy** | ☐ **Loss of appetite and body weight in cancer patients and patients with HIV/AIDS**<br>☐ **Psychiatric Disorders**<br>☐ Anxiety<br>☐ Depression<br>☐ Sleep Disorders (Insomnia)<br>☐ Post-Traumatic Stress Disorder<br>☐ Alcohol/Opioid withdrawal symptoms<br>☐ Schizophrenia<br>☐ Psychosis<br>☐ **Inflammatory Skin Diseases**<br>☐ **Other, please specify:**<br><br>**NOTE:** Please, provide pertinent Family physician/ Specialist/s Consultation/s/Case Assessment Report/s |

| **Do you believe that you know the origins of your main condition?** | ☐ Yes ☐ No |
|---|---|
| If yes, please specify: | |

**What is/are the dominant symptom/s and/or sign/s associated with the main diagnosed condition/s that you are presently experiencing for which you would like to be treated with cannabis?**

| **Are you currently treating your symptom/s from the main eligible condition?** | ☐ Yes ☐ No |
|---|---|
| If yes, please specify the type of treatment/s or therapy/pies: | ☐ **Prescribed drug/s** ☐ **Non-prescribed drug/s i.e over-the-counter medications (OTCs)**<br>☐ **Health/Nutritional/Dietary Supplement/s Vitamins, Minerals**<br>☐ Herbs<br>☐ Meal Supplements<br>☐ Sports Nutrition Products<br>☐ Natural Food Supplements<br>☐ Other Related Product/s<br>☐ **Any other form/s of therapy/pies**<br>☐ Psychotherapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy<br>☐ Physiotherapy ☐ Thermotherapy ☐ Hydrotherapy ☐ Infrared Therapy<br>☐ Electro Therapy ☐ If other, please specify:<br>☐ **Surgery** |
| If not, please briefly explain why? | |

| **Besides the main condition is there any other current condition/s you are suffering from?** | ☐ Yes ☐ No |
|---|---|
| If yes, please specify: | ☐ Head, Eyes, Ears, Nose, Mouth &Throat (HEENT) ☐ Neck<br>☐ Cardiovascular System (CVS) ☐ Respiratory System (RESP) ☐ Hematopoietic System<br>☐ Gastrointestinal System (GI) ☐ Musculoskeletal System (MSK) ☐ Lymphatic System<br>☐ Neurological (NEURO) ☐ Dermatology (DERM) Skin/Hair/Nails changes<br>☐ Genitourinary System (GU) ☐ Gynaecological (OBGYN) ☐ Endocrine (ENDO)<br>☐ Psychiatric (PSYCH) ADD, OCD, Depression, Bipolar, Schizophrenia, PTSD |

| | |
|---|---|
| **Are you currently treating your symptom/s from the other medical condition/s?** | ☐ Yes ☐ No |
| If yes, please specify what type of treatment/s or therapy/pies: | ☐ **Prescribed drug/s** ☐ **Non-prescribed drug/s i.e over-the-counter medications (OTCs)**<br>☐ **Health/Nutritional/Dietary Supplement/s Vitamins, Minerals**<br>☐ Herbs<br>☐ Meal Supplements<br>☐ Sports Nutrition Products<br>☐ Natural Food Supplements<br>☐ Other Related Product/s<br>☐ **Any other form/s of therapy/pies**<br>☐ Psychotherapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy<br>☐ Physiotherapy ☐ Thermotherapy ☐ Hydrotherapy ☐ Infrared Therapy<br>☐ Electro Therapy ☐ If other, please specify:<br>☐ **Surgery** |
| **Are you currently using Cannabis to treat any of your symptom/s?** | ☐ Yes ☐ No |
| If you are currently using Cannabis, please specify: | ☐ **Prescribed Cannabis**<br>☐ **Non prescribed Cannabis**<br>**Type:** ☐ Fresh Marijuana ☐ Dried Marijuana ☐ Cannabis Oil<br>☐ Other forms of Pharmaceutical Cannabinoids authorized for prescription by Health Canada<br>☐ Nabiximols [Sativex®]<br>☐ Nabilone [Cesamet®]<br>☐ Dronabinol [Marinol®]<br>**Daily Amount:** ☐ ___g/d ☐ ___joints/d<br>**THC Percentage:** ☐ <9%THC ☐ Other, please specify: ___<br>**Length of Period Taken:** ☐ ___Day/s ☐ ___Week/s ☐ ___Month/s ☐ ___Year/s<br>**Frequency Taken:** ☐ Daily ☐ Weekly ☐ Monthly ☐ If other, please specify:<br>**Method and form of Administration:**<br>☐ **Inhalation:** ☐ Smoking (Involves burning the flowers and inhaling the released active components of the plant)<br>☐ Vaporizing (Involves heating the plant and inhaling the released active components of the plant)<br>☐ **Oral:** ☐ Edibles ☐ Tinctures ☐ Capsules [Cesamet®, Marinol®] ☐ Oils<br>☐ **Sublingual:** ☐ Dissolvable strips ☐ Sublingual sprays [Sativex®] ☐ Medicated lozenges ☐ Tinctures<br>☐ **Topical:** ☐ Lotions ☐ Salves ☐ Bath salts ☐ Oils applied to the skin ☐ Lip balms<br>☐ **Other**, please specify: |
| If you are currently using **EDIBLES** (food/drinks infused with Cannabis extract) please specify what kind: | ☐ Cookies ☐ Meatballs ☐ Meal Replacements ☐ Biscuits<br>☐ Rice Crispy Bars ☐ Brownies ☐ Mousse ☐ Dressing ☐ Salads<br>☐ Soups ☐ Muffins ☐ Teas ☐ Juices ☐ Cream cones ☐ Bacon<br>☐ Pesto ☐ Candies ☐ Buds ☐ Samosas ☐ Gummies,<br>☐ Maple syrup ☐ Honey ☐ Lollypops ☐ Butters ☐ Tinctures<br>☐ Oils ☐ Veggie Capsules<br>☐ Cannabis-infused drinks/liquid edibles or drinkables<br>☐ Liqueurs (brandy or rum infused with cannabinoids) |
| **Has any of the current treatment/s reduced the symptom/s that you were experiencing prior to the use of that treatment/s?** | ☐ Yes ☐ No |
| If yes, please specify which treatment/s, therapy/pies has reduced your symptoms: | |
| What you have improved using the current treatment/s or therapy/pies? | ☐ Physical functioning/General Activity ☐ Sleep patterns ☐ Mood ☐ Appetite ☐ Ability to concentrate<br>☐ Family relationships ☐ Social relationships ☐ OutsideWork ☐ Home/Housework<br>☐ Enjoyment of life ☐ Overall functioning |
| **Have you experienced any side or adverse effects with any of your present treatment/s or therapy/pies?** | ☐ Yes ☐ No |
| If yes, please specify which treatment/s or therapy/pies you believe has caused the side or adverse effect/s: | |
| **What is the current treatment/s or therapy/pies side effect(s)?** | ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Upset Stomach ☐ Diarrhea ☐ Constipation ☐ Dry Mouth<br>☐ Abdominal Pain ☐ Rash ☐ Itching ☐ Hives ☐ Swelling of the lip and tongue ☐ Headache<br>☐ Memory impairment ☐ Confusion ☐ Hallucinations ☐ Dizziness ☐ Sedation ☐ Delirium<br>☐ Sweating ☐ Cold flashes ☐ Fatigue ☐ Insomnia ☐ Unexplained weight loss ☐ Seizures<br>☐ Slow heart beats ☐ Rapid heart beats ☐ Orthostatic Hypotension ☐ High Blood Pressure<br>☐ Urinary retention ☐ Involuntary leg movements ☐ Sharp bone and muscle pains<br>☐ Extreme agitation or irritability ☐ Increasing hostility ☐ Feelings of paranoia<br>☐ Unsteady movements and/or mannerisms Involuntary gestures, movements or tics<br>☐ Rapid, involuntary eyes movement ☐ Poor judgment and decision-making<br>☐ Other, please specify: |

| | | | |
|---|---|---|---|
| **Has your Family Physician/Specialist/s used any diagnostic test to determine the nature or severity of that main condition?** | | ☐ Yes | ☐ No |
| If yes, please specify which diagnostic test/s: | | | |
| **Do you suffer from allergies or sensitivities?** | | ☐ Yes | ☐ No |
| If "Yes" what kind? | ☐ Medications ☐ Food ☐ Insects ☐ Animals ☐ Latex<br>☐ Health/Nutritional/Dietary Supplements ☐ If any other, please specify:<br>**Describe reaction/s you have:** | | |
| **Do you currently use any street drug/s, solvent/s or any other addictive substance/s?** | | ☐ Yes | ☐ No |
| If "Yes" what kind? | ☐ **Alcohol**<br>☐ **Tobacco/Nicotine**<br>☐ **Inhalants/Solvents:** Aerosols (such as deodorants, air freshener, hairspray), nail polish or nail polish remover, glue, paint remover, shoe polish, petrol, cigarette lighter fluid. It can be called sniffing, tooting, huffing, dusting, or buzzing gas.<br>☐ **Psychedelic or hallucinogenic mushrooms:** (shrooms, mushies, magics, philosopher's stone)<br>☐ **Opioids:** morphine, heroin or diamorphine (H, smack, skag, gear, brown), methadone, codeine, oxycontin.<br>☐ **Barbiturates / Benzodiazepines**<br>☐ **Amphetamines:** (common street name "speed", whizz, sulph, dexies.)<br>☐ **Methamfetamines:** (yaba, glass, meth, crank)<br>☐ **Mephedrone:** (meow meow, miaow, m smack, m cat, drone, bubble, white, mc, charge)<br>☐ **Cannabis:** (marijuana, grass, hemp, weed, pot, hash, hashish, dope, ganja, skunk, puff)<br>☐ **Cocaine:** (H, smack, skag, gear, brown)<br>☐ **Ketamine:** (K, vitamin K, super K, special K, green, donkey dust)<br>☐ **Hallucinogens**: **LSD** (Lysergic Acid Diethylamide), mescaline, psilocybin, PC<br>☐ **"Club Drugs":** Ecstasy, "Molly" (MDMA), GHB, ketamine, rohypnol, crystal meth<br>☐ **If any other, please specify:**<br>**Describe type/quantity/frequency/date of most recent use:** | | |
| If Tobacco, what type of use? | ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Dissolvable Tobacco ☐ Bidis<br>☐ Hookah/Shisha ☐ Electronic cigarette or E- cigarette ☐ Kreteks/Clove cigarettes<br>☐ Snuff (finely ground tobacco that can be dry, moist, or packaged in pouches or packets)<br>☐ Chew (loose leaf, plug, twist or roll) ☐ Dissolvable (Lozenges, Orbs, Sticks, Strips) | | |
| Quantify your use: | # of years have you used Tobacco? | If you have quitt, for how long? | |
| If Alcohol, what kind? | **Undistilled (low alcohol content, typically less than 15%):**<br>☐ Beer ☐ Wine ☐ Cider<br>**Distilled ("harder" or stronger than 30%):**<br>☐ Vodka ☐ Gin ☐ Baijiu ☐ Tequila ☐ Rum ☐ Whisky ☐ Brandy ☐ Soju | | |
| Quantify your use: | # of years have you consumed Alcohol? | If you have quitt, for how long? | |
| **Have you previously received or are you presently receiving any other form of treatment/therapy/program for substance dependence?** | | ☐ Yes | ☐ No |
| If "Yes" what kind? | ☐ **Outpatient setting Detoxification/Medically Managed Withdrawal**<br>☐ **Inpatient setting Detoxification/Medically Managed Withdrawal**<br>☐ **Long-Term Residential Treatment/Therapeutic Community (TC)**<br>(planned lengths of stay of between 6 and 12 months)<br>☐ **Short-Term Residential Treatment**<br>(3- to 6-week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as AA) | | |
| **Do you have any children?** | | ☐ Yes | ☐ No |
| If not, is it your intention to do so? | | ☐ Yes | ☐ No |
| **Are you presently pregnant, planning to be pregnant or breastfeeding?** | | ☐ Yes ☐ No | ☐ N/A |
| If not, is it your intention to do so? | | ☐ Yes ☐ No | ☐ N/A |

**Do you have family history of?**
☐ Cancer ☐ Diabetes Mellitus ☐ Hypertension ☐ Heart disease ☐ Thyroid disease ☐ Hypercholesterolemia ☐ Stroke ☐ Anemia ☐ Arthritis
☐ Asthma ☐ Epilepsy ☐ Headaches ☐ Kidney disease ☐ Hereditary autoimmune ☐ Hematological ☐ Eczema ☐ Psoriasis
☐ Substance Dependence ☐ Mental disorders

| | |
|---|---|
| **Which member(s) of your family suffers from the check marked condition/s?**<br>☐ Father ☐ Paternal Grandfather ☐ Paternal Grandmother ☐ Mother ☐ Maternal Grandfather ☐ Maternal Grandmother ☐ Sibling(s) | |
| **Do children or young persons under 18 live at your home?** | ☐ Yes ☐ No |
| **Do you reside with any adult?** | ☐ Yes ☐ No |
| **Do you use any equipment/article/machinery in your employment or at home that can result in any physical injury?** | ☐ Yes ☐ No |
| **Do you operate an automobile?** | ☐ Yes ☐ No |
| **What are your goals regarding your treatment regimen that you would like to achieve during this visit?** | ☐ Adjust dose of present treatment regimen<br>☐ Taper off present treatment regimen<br>☐ Discontinue present treatment regimen<br>☐ Add Cannabis to my present treatment regimen<br>☐ Switch present treatment regimen to Cannabis<br>☐ Adjust my current prescribed Cannabis dosage<br>☐ Continue present Cannabis regimen |
| **What would you like to improve with your treatment regimen?** | ☐ Physical functioning/General Activity ☐ Sleep patterns ☐ Mood ☐ Appetite ☐ Ability to concentrate<br>☐ Family relationships ☐ Social relationships ☐ OutsideWork ☐ Home/Housework<br>☐ Enjoyment of life ☐ Overall functioning |
| **PHQ-9 Patient Depression Questionnaire Score** | ☐ Minimal ☐ Mild ☐ Moderate<br>☐ Moderately severe ☐ Severe ☐ N/A |
| **GAD-7 Scale (General Anxiety Disorder-7 item) Score** | ☐ Minimal ☐ Mild ☐ Moderate<br>☐ Moderately severe ☐ Severe ☐ N/A |
| **CAGE-AID Questionnaire Score**<br>*** Standard drink**<br>= 1 bottle beer (12 oz, 5%)<br>= 5 oz glass wine (5 standard drinks in 750 ml wine bottle)<br>= 1.5 oz liquor (vodka, scotch) (18 standard drinks in 26 oz bottle 40% alcohol)<br>**Low-Risk Drinking Guidelines**<br>— Source: Centre for Addiction and Mental Health (CAMH) 2004<br>(No more than 2 standard drinks on any one day)<br>**Women:** up to 9 standard drinks a week.<br>**Men:** up to 14 standard drinks a week.<br>Patients who exceed the Low-Risk Drinking Guidelines are considered at-risk for acute problems such as trauma, and/or chronic problems such as depression and hypertension. | ☐ Yes<br>☐ No<br>☐ Clinical significant<br>☐ N/A |
| **OPIOID RISK TOOL Score** | ☐ Low ☐ Moderate ☐ High Risk ☐ N/A |
| **THE DRUG ABUSE SCREENING TEST (DAST)** | ☐ < 12 ☐ >12 |
| **PAIN ASSESSMENT TOOL Score** | ☐ Slight ☐ Mild ☐ Moderate ☐ Severe<br>☐ Very Severe ☐ The Most Intense Pain Imaginable<br>☐ N/A |
| **Have you been provided with a hard copy, read, fully understood, completed and signed the following documents?** | ☐ Health Canada's Consumer Information-Cannabis<br>☐ Patient's Treatment Information Document<br>☐ Side Effect Log Form<br>☐ Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines to report any suspected serious adverse reactions while using or associated with the use of Cannabis products<br>☐ Urine Drugs and/or Alcohol Testing Consent/Refusal Form<br>☐ Consent to use Electronic Communications<br>☐ Consent to Obtain Information on Products and Consent for authorizing the Clinic/Physician to confirm information contained within the medical document upon request by the Authorized Licensed Producer/Health Canada<br>☐ Consent to Medical Translation and Interpretation<br>☐ Consent to Treatment<br>☐ Release Form for Medical Practitioner<br>☐ 12 Months Patient's Follow Up Plan<br>☐ Quality of Care Patient's Survey |

## PATIENT'S INFORMATION SOURCES

☐ Patient ☐ Patient's relative ☐ Substitute Decision Maker (SDMS) ☐ Translator ☐ If other, specify:

## CONFIRMATION OF ACCURACY OF INFORMATION PROVIDED

I certify, that I have reviewed the information provided herein and I confirm that it is accurate.

Source of Information's Name and Signature:

**If services of interpreter are provided,**

☐ I confirm that I fully understood the translation/interpretation provided to me and I have provided accurate information through the translator/ interpreter upon review with the interpreter.

Patient's Name and Signature:

## PRIMARY CARE PROVIDER INFORMATION

| Name: | Phone Number: | Province of Medical Practice: |
|---|---|---|

## SPECIALIST/S INFORMATION

| Name: | Phone Number: | Province of Medical Practice: |
|---|---|---|