DEPARTMENT OF HEALTH

Patient Self-Evaluation: Standard Form

Name:

Registry ID (P########): P

Date:

Measurements

Height Feet: Inches: *Weight (lbs):*

Please list all current medical diagnoses

Please list any current medications you are taking (including over-the-counter and other prescribed medications)

Medication Name	Dosage (e.g., 200 mg, 30 mL, etc.)	Frequency (e.g., every 4 hrs, twice a day, etc.)

Symptom Evaluation Questions

Instructions: People with medical conditions often have symptoms that are caused by their disease or by disease treatments. Please rate how severe the following symptoms have been *in the last 24 hours*. CIRCLE below from 0 (symptom has not been present) to 10 (the symptom was as bad as you can imagine it could be) for each item.

Your pain at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your fatigue (tiredness) at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your nausea at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your disturbed sleep at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your feelings of anxiety (nervous) at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your problem with lack of appetite at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your feeling sad (depressed) at its worst:

Not present										As bad as you can imagine
0	1	2	3	4	5	6	7	8	9	10

Your vomiting at its worst:

Not present — As bad as you can imagine

0 1 2 3 4 5 6 7 8 9 10

What, if any, benefits have you experienced as a result of taking medical cannabis? Please list benefits in order of importance to you:

Check and rate the severity of any side effects you believe are related to the medical cannabis you are taking below:

SYMPTOM SEVERITY: DEFINITIONS

Mild: Symptoms do not interfere with daily activities
Moderate: Symptoms may interfere with daily activities
Severe: Symptoms interrupt usual daily activities

✓	Symptom	Severity (circle one)	Comments
	Dizziness	Mild Moderate Severe	
	Fatigue	Mild Moderate Severe	
	Dry mouth	Mild Moderate Severe	
	Lightheadedness	Mild Moderate Severe	
	Drowsiness/somnolence/sedation	Mild Moderate Severe	
	Nausea	Mild Moderate Severe	
	Headache	Mild Moderate Severe	
	Diarrhea	Mild Moderate Severe	
	Confusion	Mild Moderate Severe	

✓	Symptom	Severity (circle one)	Comments
	Mental clouding/"foggy brain"	Mild Moderate Severe	
	Asthenia (muscle weakness)	Mild Moderate Severe	
	Constipation	Mild Moderate Severe	
	Blurred vision	Mild Moderate Severe	
	Increased appetite	Mild Moderate Severe	
	Euphoria (intense feeling of well-being or pleasure)	Mild Moderate Severe	
	Anxiety	Mild Moderate Severe	
	Insomnia	Mild Moderate Severe	
	Disorientation	Mild Moderate Severe	
	Abdominal/epigastric pain	Mild Moderate Severe	
	Difficulty concentrating	Mild Moderate Severe	
	Panic attack	Mild Moderate Severe	
	Numbness	Mild Moderate Severe	
	Slurred speech	Mild Moderate Severe	
	Impaired memory	Mild Moderate Severe	
	Tinnitus (ringing perception in the ears)	Mild Moderate Severe	
	Vomiting	Mild Moderate Severe	
	Chest pain	Mild Moderate Severe	
	Tachycardia (rapid heart rate)	Mild Moderate Severe	
	Dysphoria (intense feeling of unease or unpleasantness)	Mild Moderate Severe	
	Paranoia	Mild Moderate Severe	
	Tremor	Mild Moderate Severe	
	Other:	Mild Moderate Severe	
	Other:	Mild Moderate Severe	
	Other:	Mild Moderate Severe	
	Other:	Mild Moderate Severe	

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