TIMEWISE MEDICAL

MEDICAL CANNABIS RECERTIFICATIONS

Patient Name: _____Date of Birth: _____

Email Address: _____ Qualifying Condition:_____

1. Please circle the number corresponding with your pain levels today:
   1 2 3 4 5 6 7 8 9 10

Are you currently pregnant? YES NO
Diagnosed with Schizophrenia or Schizoaffective Disorder? YES NO

2. Please list your typical Cannabis products that you use. Please include dosage:

_____

_____

3. Please list any and all prescription medication changes and/or alterations since starting Medical Cannabis in detail, including dosage:

_____

_____

4. Please list all symptom improvements that you have noticed since starting Medical Cannabis:

_____

_____

5. Please list any side effects that you have experienced from the Medical Cannabis:

_____

_____

X_____ _____

Patient Signature Date: