THC Questionnaire

Submit the form when you have answered all that you can

Name

First Name Last Name

Date of Birth

Month Day Year

Gender

Female Male

Marital Status

- Single
- Married
- Domestic Partner
- Separated
- Divorced
- Widowed

Email

example@example.com

Phone Number

Please enter a valid phone number.

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Preferred contact method

- ○ Mobile Phone
- ○ Home Phone
- ○ Work Phone
- ○ Email

Social Security (last 5 numbers only).

Reason for medical evaluation:

Do you have any of these symptoms?

- ☐ Fever/Chills
- ☐ Unexplained weight loss
- ☐ Night Sweats
- ☐ Dizzy/Lightheaded
- ☐ Headache
- ☐ Blurry/double vision
- ☐ Loss of vision
- ☐ Ear ringing
- ☐ Facial pain/numbness

- [ ] Hoarseness
- [ ] Persistent of breath
- [ ] Heart Palpitation
- [ ] Abdominal pain
- [ ] Constipation
- [ ] Nausea/Vomiting
- [ ] Swollen Glands
- [ ] Nose bleeds
- [ ] Angina/Chest Pain
- [ ] Leg Pain with walking
- [ ] Blood in stool
- [ ] Diarrhea
- [ ] Blood in urine
- [ ] Blood Clots
- [ ] Blood in Sputum
- [ ] Ankle swelling
- [ ] Wake short of breath
- [ ] Bloating
- [ ] Heartburn
- [ ] Heavy/Painful menses
- [ ] Bleeding easily

Do you have now or have you ever had:

	Yes	No	If Yes, Explain briefly
Anxiety	○	○	
Severe COPD	○	○	
Arthritis	○	○	
Bowel Disease	○	○	
Diabetes Type I	○	○	
Heart Attack/Stroke	○	○	
High Blood Pressure	○	○	
Kidney Disease	○	○	
Liver Disease	○	○	
Neurologic Disorder	○	○	
Osteoporosis	○	○	
Seizures/Epilepsy	○	○	
Thyroid Problems	○	○	
Dementia	○	○	
Parkinson's Disease	○	○	
Spasticity	○	○	
Degenerative joint disease	○	○	
Terminal Cancer	○	○	

Chronic Traumatic Encephalopathy	○	○	
Multiple Sclerosis	○	○	
Amyotrophic Lateral Sclerosis (ALS)	○	○	
Peripheral Neuropathy	○	○	
Cerebral Palsy	○	○	
Meningitis	○	○	
Other Neurodegenerative disorder	○	○	

Do you have now or have you ever had:

	Yes	No	Location/Type
Cancer	○	○	
Radiation	○	○	
Chemotherapy	○	○	

Surgical History

	Type of Surgery	Month/Year
Surgery 1		
Surgery 2		
Surgery 3		

Medication List

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				
4				
5				
6				

7				
8				
9				
10				

Allergies

	Allergy	Reaction
1		
2		
3		
4		

Do you:

	Yes	No	How many per day(packs/drinks)	Years
Smoke?	○	○		
Drink Alcohol?	○	○		

Use recreational drugs?

	Yes	No	If yes, please list what kind:
1	○	○	

Do you have a family (parent, sibling or child) history of:

	Yes	No	If yes, who?
Heart Disease/Stroke	○	○	
High Blood Pressure	○	○	
Diabetes	○	○	
Cancer (specify Type)	○	○	
Other	○	○	

Do you exercise?

	Yes	No	If yes, how much?
1	○	○	

Do you feel that there is a lack of QUALITY in your life because of your medical condition(s)

Weight

Height

Have you undergone a surgery before?

- ○ Yes
- ○ No

Arrests and/or convictions? If you answered YES explain? (this will not determine if you're a qualifying candidate for THC treatment or not)

Are you on parole or probation? If you answer YES, explain. (this will not determined if you're a qualifying candidate for THC treatment or not)

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Have you been prescribe medical cannabis in the state of Texas? If you answered YES, explain.