



Kentucky Medical Cannabis Certificates, LLC

501 Darby Creek Road, Unit 58
Lexington, KY 40509
spenser@kymedcannabiscert.com

MEDICAL QUESTIONNAIRE

Please fill out the information below to the best of your knowledge. If the question does not apply to you, please leave it blank.

MEDICAL HISTORY
Past medical history (Such as diabetes, high blood pressure, back pain, etc...):
Current Prescription and Over-the-Counter Medications:
Medication Allergies:
Tobacco use (Packs/Per Day, Years Used): _____
Alcohol use (Drinks/Per Day, Years Used): _____
Illicit drug use (Quantity/Per Day, Years Used): _____
TREATMENT EFFECTIVENESS FOR QUALIFYING CONDITION
Please answer the following questions on how effective your current treatment plan is for your medical condition.
Current treatments (medications, therapy, etc...) for your medical condition:
How effective are these treatments? NOT AT ALL MILD MODERATE SIGNIFICANT
<u>For individuals renewing their medical cannabis card:</u>
How effective is medical cannabis in your treatment? NOT AT ALL MILD MODERATE SIGNIFICANT
Are you having any side effects from medical cannabis? _____ _____



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I certify the above information is true and correct:

Printed Name:

Date of Birth:

Patient Signature:

Date: