

CanCaRE Intake Questionnaire

Please complete this form to help us better understand your medical history, current medications, and status of various symptoms. Your responses will allow our team to be better prepared and spend more time during the visit discussing safe and effective ways to incorporate cannabis into your care plan.

What was your primary reason for scheduling a visit with the CanCaRE clinic?

With which of the following types of cancer have you been diagnosed? Please check all that apply.

- Bladder Cancer
- Breast Cancer
- Colon/Rectal Cancer
- Esophageal
- Glioblastoma/Gliomas
- Gynecological Cancer (e.g., ovary, uterus, cervix)
- Head/neck Cancer (e.g., tonsil, throat, mouth)
- Kidney Cancer
- Leukemia
- Lymphoma
- Lung Cancer
- Melanoma
- Non-melanoma skin cancer (e.g. basal cell or squamous cell skin cancer)
- Myeloma
- Pancreas Cancer
- Prostate Cancer
- Other Cancer

What other cancer have you been diagnosed with?

For which of the diagnoses are you currently receiving treatment?

Have you been diagnosed with any of the following conditions? Please note that we are asking about these conditions as they might impact your ability to tolerate cannabis.
(check all that apply).

- Heart disease (including heart attacks, congestive heart failure, high blood pressure)
- Lung disease (including COPD, asthma, pulmonary fibrosis)
- Neurologic disease (including epilepsy/seizures, dementia)
- Gastrointestinal disease (including gastric bypass surgery, inflammatory bowel disease, liver cirrhosis or hepatitis)
- Post-traumatic stress disorder
- Schizophrenia or schizoaffective disorder
- Pregnant, or plan to become pregnant in near future

Have you seen a clinician for cancer management within the last year?

- Yes
- No

Oncologist Name:

Are you currently receiving treatment for your cancer?

- Yes
 No

The following questions are about your current cancer.

What is your current cancer stage?

- Stage I
 Stage II
 Stage III
 Stage IV (often referred to as "metastatic")
 Don't know

What year was your cancer first diagnosed? If you do not know the exact year, your best guess is okay.

(yyyy)

Which cancer therapy are you currently using to treat your cancer? (check all that apply)

- Surgery
 Radiation
 Chemotherapy (oral or IV medications)
 Immunotherapy (medications often given via IV such as nivolumab, pembrolizumab, ipilimumab and others)
 Hormone-blocking pills or shots (e.g., anti-estrogen treatment for breast cancer, or anti-testosterone treatments for prostate cancer)
 Other complementary or alternative therapies (e.g., herbal supplements, acupuncture, specific "anti-cancer" diet)
 Other treatment(s): Please specify what other therapies you currently use to treat your cancer

Please specify what other therapies you currently use to treat your cancer:

Which therapies have you used in the past? (check all that apply)

- Surgery
 Radiation
 Chemotherapy (oral or IV medications)
 Immunotherapy (medications often given via IV such as nivolumab, pembrolizumab, ipilimumab and others)
 Hormone-blocking pills or shots (e.g., anti-estrogen treatment for breast cancer, or anti-testosterone treatments for prostate cancer)
 Other complementary or alternative therapies (e.g., herbal supplements, acupuncture, specific "anti-cancer" diet)
 Other treatment(s): Please specify what other therapies you have used to treat your cancer in the past

Please specify what other therapies you have used to treat your cancer in the past:

The following questions are about the therapies you have used (or are using) to treat your cancer.

Surgical Treatment

When was your surgery? If you've had multiple surgeries, when was your most recent one? If you do not know the exact year, your best guess is okay.

(yyyy)

Radiation Therapy

When did you start receiving radiation? If you do not know the exact year, your best guess is okay.

(yyyy)

Chemotherapy Treatment

When did you start chemotherapy?

(yyyy)

What was the name of the medication you used (or use) during your chemotherapy treatment?

(If unsure leave blank.)

Immunotherapy Treatment

When did you start Immunotherapy (IV medications such as nivolumab, pembrolizumab, ipilimumab and others)?

(yyyy)

What was the name of the medication you used (or use) during your Immunotherapy treatment?

(If unsure leave blank.)

Hormone Therapy

When did you start Hormone-blocking pills or shots (e.g., anti-estrogen treatment for breast cancer, or anti-testosterone treatments for prostate cancer)?

(yyyy)

What was the name of the medication you used (or use) during your Hormone-blocking pills or shots treatment?

(If unsure leave blank.)

Alternative Treatment(s)

When did you start using other complementary or alternative therapies (e.g., herbal supplements, acupuncture, specific "anti-cancer" diet)?

(yyyy)

As individuals go through treatment for their cancer they sometimes experience different symptoms and side effects. For each question, please select the one response that best describes your experiences over the past 7 days...

In the last 7 days, how OFTEN did you have PAIN?

- Almost constantly
 - Frequently
 - Occasionally
 - Rarely
 - Never
-

In the last 7 days, what was the SEVERITY of your PAIN at its WORST?

- Very severe
 - Severe
 - Moderate
 - Mild
 - None
-

In the last 7 days, how much did PAIN INTERFERE with your usual or daily activities?

- Very much
 - Quite a bit
 - Somewhat
 - A little bit
 - Not at all
-

In the last 7 days, what was the SEVERITY of your NUMBNESS OR TINGLING IN YOUR HANDS OR FEET at its WORST?

- Very severe
 - Severe
 - Moderate
 - Mild
 - None
-

In the last 7 days, how much did NUMBNESS OR TINGLING IN YOUR HANDS OR FEET INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, how OFTEN did you have NAUSEA?

- Almost constantly
- Frequently
- Occasionally
- Rarely
- Never

In the last 7 days, what was the SEVERITY of your NAUSEA at its WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how OFTEN did you have VOMITING?

- Almost constantly
- Frequently
- Occasionally
- Rarely
- Never

In the last 7 days, what was the SEVERITY of your VOMITING at its WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, what was the SEVERITY of your DECREASED APPETITE at its WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did DECREASED APPETITE INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, what was the SEVERITY of your INSOMNIA (INCLUDING DIFFICULTY FALLING ASLEEP, STAYING ASLEEP, OR WAKING UP EARLY) at its WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did INSOMNIA (INCLUDING DIFFICULTY FALLING ASLEEP, STAYING ASLEEP, OR WAKING UP EARLY) INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, how OFTEN did you feel ANXIETY?

- Almost constantly
- Frequently
- Occasionally
- Rarely
- Never

In the last 7 days, what was the SEVERITY of your ANXIETY at its WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did ANXIETY INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, how OFTEN did you have SAD OR UNHAPPY FEELINGS?

- Almost constantly
- Frequently
- Occasionally
- Rarely
- Never

In the last 7 days, what was the SEVERITY of your SAD OR UNHAPPY FEELINGS at their WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did SAD OR UNHAPPY FEELINGS INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, what was the SEVERITY of your DRY MOUTH at their WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, what was the SEVERITY of your DIZZINESS at their WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did DIZZINESS INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, what was the SEVERITY of your PROBLEMS WITH CONCENTRATION at their WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did PROBLEMS WITH CONCENTRATION INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

In the last 7 days, what was the SEVERITY of your FATIGUE, TIREDNESS, OR LACK OF ENERGY at their WORST?

- Very severe
- Severe
- Moderate
- Mild
- None

In the last 7 days, how much did FATIGUE, TIREDNESS, OR LACK OF ENERGY INTERFERE with your usual or daily activities?

- Very much
- Quite a bit
- Somewhat
- A little bit
- Not at all

Do you have any other symptoms that you wish to report?

- Yes
 No

List one symptom not described above:

[oth_symp1]

In the last 7 days, what was the SEVERITY of this symptom ([oth_symp1]) at its WORST?

- Very severe
 Severe
 Moderate
 Mild
 None

Do you have any other symptoms that you wish to report?

- Yes
 No

List one symptom not described above:

[oth_symp2]

In the last 7 days, what was the SEVERITY of this symptom ([oth_symp2]) at its WORST?

- Very severe
 Severe
 Moderate
 Mild
 None

Do you have any other symptoms that you wish to report?

- Yes
 No

List one symptom not described above:

[oth_symp3]

In the last 7 days, what was the SEVERITY of this symptom ([oth_symp2]) at its WORST?

- Very severe
 Severe
 Moderate
 Mild
 None

Do you have any other symptoms that you wish to report?

- Yes
 No

List one symptom not described above:

[oth_symp4]

In the last 7 days, what was the SEVERITY of this symptom ([oth_symp2]) at its WORST?

- Very severe
 Severe
 Moderate
 Mild
 None

Do you have any other symptoms that you wish to report?

- Yes
 No

List one symptom not described above:

[oth_symp5]

In the last 7 days, what was the SEVERITY of this symptom ([oth_symp2]) at its WORST?

- Very severe
 Severe
 Moderate
 Mild
 None

We would like to better understand your experience with cannabis (marijuana) and cannabis-related products like cannabidiol (CBD). Marijuana is another name for cannabis. In the questions below we use the term "cannabis" to refer to both cannabis and marijuana.

Have you ever been enrolled in MN Cannabis Program?

- Yes
 No

Have you ever tried any type of cannabis, including those with CBD and/or THC to help your cancer symptoms?

- Yes
 No

Do you currently use cannabis to help your cancer symptoms?

- Yes
 No

How much benefit, if any, have you experienced by using cannabis?

- No benefit
- A little benefit
- Some benefit
- Quite a bit of benefit
- A great deal of benefit

Please mark which symptoms you feel cannabis has helped improve (check all symptoms that cannabis has provided at least a little benefit).

- Pain
- Nausea
- Appetite
- Neuropathy (numbness/tingling)
- Sleep
- Anxiety
- Depression
- Other (please list)

Please specify other symptom:

Have you ever used cannabis to treat your cancer (for example, in attempt to shrink a mass on imaging or improve a lab marker)?

- Yes
- No

Do you currently use cannabis to treat your cancer?

- Yes
- No

How often do you use cannabis? If it varies, choose the response that most often describes your cannabis use.

- Every day
- Almost every day
- About once a week
- Less than once a week
- It varies

What cannabis products do you currently use? Check all that apply.

- Cannabis with THC component that is lab tested for purity and potency.
- Cannabis with THC component that is NOT lab tested for purity and potency
- CBD-only product typically purchased online or over the counter (e.g., CBD oils/capsules/hemp oil)
- Other cannabis product

What other cannabis products are you using?

Where do you get cannabis? Please check all that apply.

- I grow it myself
- Someone grows it for me as part of medical co-op
- I get it from a friend or a local dealer
- I get it from a state-sponsored medical dispensary
- I get it from a recreational marijuana store/dispensary
- I get it somewhere else

Where else do you get cannabis?

How do you typically use cannabis? Check all that apply.

- Inhaled by vaporizing or smoking or dabbing, such as with a pen, flower vape, bong, joint/cigarette/pipe or similar
- Swallowed cannabis products such as tincture, oil, capsules, lozenges, edibles like brownies, cookies or candy.
- Drink it, for example, in tea, cola, or alcohol.
- Topical, such as cream, ointment, salve or transdermal patch
- Suppository or pessary for rectal or vaginal use
- Use it some other way

How else do you use cannabis?

What ratio of THC/CBD is in the cannabis you use? Check all that apply.

- High THC, low CBD
- Balanced THC/CBD ratio
- High CBD, low THC
- CBD-only
- Don't know

How often do you take cannabis with food?

- Never
- Sometimes
- Always

Who gives you instructions on how to use cannabis and how much to take? Check all that apply.

- Cancer doctor/nurse practitioner/physician assistant/nurse
- Primary care doctor/nurse practitioner/physician assistant/nurse
- Palliative care doctor/nurse practitioner/physician assistant/nurse
- Cannabis pharmacist
- Friends or family
- Online sources (Blogs, social networking groups, etc)
- Some other source
- No one

What other source(s) are you using for instruction on how to use cannabis and/or how much to take?

In an average month, approximately how much money do you spend on cannabis?

- Less than \$50 US Dollars
- \$50-\$99 US Dollars
- \$100-\$199 US Dollars
- \$200-\$299 US Dollars
- \$300-\$399 US Dollars
- \$400 US Dollars or more

Approximately how much money would you be willing to spend on cannabis?

- Less than \$50 US Dollars
- \$50-\$99 US Dollars
- \$100-\$199 US Dollars
- \$200-\$299 US Dollars
- \$300-\$399 US Dollars
- \$400 US Dollars or more

How much negative impact, if any, have you experienced by using cannabis?

- No negative impact
- A little negative impact
- Some negative impact
- Quite a bit of negative impact
- A great deal of negative impact

Other negative effects, please specify:

- Physical side effects related to medical cannabis use (stomach upset, fatigue, headache, blurred vision, etc.)
- Mental/cognitive side effects related to medical cannabis use (mental clouding, confusion, depression, etc.)
- Worsening of symptoms related to the condition being treated
- Difficulty/inconvenience in accessing medical cannabis
- Other negative effects, please specify:

Other negative effects, please specify:

Have you experienced other benefits from cannabis use? If so, please explain.

Have you ever gone to the emergency room and/or been hospitalized due to side effects from cannabis use?

- Yes
- No

Next we will ask about your current medicines. Answer as best as you can. We will review missing information at your visit.

Please select all medicines that you are currently taking. Check all that apply:

Opioids:

- Codeine (Tylenol #3)
- Fentanyl patch
- Hydrocodone (Norco/Vicodin)
- Hydromorphone (Dilaudid)
- Tramadol
- Methadone
- Morphine
- Morphine sustained release (SR) or extended release (ER) (MS-contin)
- Oxycodone (Percocet)
- Oxycodone controlled release (CR) (Oxycontin)

Codeine (Tylenol #3) dose:

(mg)

How often do you typically take Codeine (Tylenol #3)?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Strength of Fentanyl patch:

(micrograms/hour)

Hydrocodone (Norco/Vicodin) dose:

(mg)

How often do you typically take Hydrocodone (Norco/Vicodin)?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Hydromorphone (Dilaudid) dose:

(mg)

How often do you typically take Hydromorphone (Dilaudid)?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Tramadol dose:

(mg)

How often do you typically take Tramadol?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Methadone dose:

(mg)

How often do you typically take Methadone?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Morphine dose:

(mg)

How often do you typically take Morphine?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Morphine sustained release (SR) or extended release (ER) (MS-contin) dose:

(mg)

How often do you typically take Morphine sustained release (SR) or extended release (ER) (MS-contin)?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Oxycodone (Percocet) dose:

(mg)

How often do you typically take Oxycodone (Percocet)?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Oxycodone controlled release (CR) (Oxycontin) dose:

(mg)

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How often do you typically take Oxycodone controlled release (CR) (Oxycontin)?

- once a day
- twice a day
- three times a day
- more than 3 times a day

Other pain medications:

- Acetaminophen (Tylenol)
- Ibuprofen (Advil)
- Aspirin
- Dexamethasone
- Lidocaine
- Gabapentin (Neurontin)

Antiemetics (anti-nausea medications)

- Ondansetron (Zofran)
- Prochlorperazine (Compazine)
- Dronabinol (Marinol)
- Dexamethasone
- Granisetron (Kytril)
- Fosaprepitant (Emend)
- Olanzapine (Zyprexa)

Sleep medications:

- Trazodone
- Diphenhydramine (Benadryl)
- Zolpidem (Ambien)
- Olanzapine (Zyprexa)
- Temazepam (Restoril)
- Over The Counter (melatonin, Tylenol PM, etc.)

Please list OTC sleep medications:

Anti-anxiety/antidepressant medications

- Lorazepam (Ativan)
- Alprazolam (Xanax)
- Citalopram (Celexa)
- Sertraline (Zoloft)
- Venlafaxine (Effexor)
- Bupropion (Wellbutrin)
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)
- other (please list)

Other anti-anxiety/antidepressant medications:

Please answer the following questions about you.

What is your current gender identity: How do you currently describe yourself?

- Male
- Female
- Transgender
- None of these

What is your current gender identity?

Do you consider yourself to be Hispanic or Latino?

- No, not Hispanic/Latino
- Yes, Hispanic/Latino

Which of the following do you consider yourself? Check all that apply.

- Asian
- Black or African American
- White
- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander
- Other, please specify below

Please specify:

Thank you for taking the time to complete this intake form.