PATIENT JOURNAL

Patient ID: _____

MED PHARM
IOWA

MEDICAL CANNABIS RESEARCH INITIATIVE

The Together We Cann program is an effort by MedPharm Iowa to collect and evaluate information about Iowa's Medical Cannabis Program. Researchers will use this information to learn more about how the program is working and about the benefits and side effects reported by patients.

Data collected and analyzed by Together We Cann may include information from patient diaries, patient intake forms, product purchase information, and survey-based data and responses. Personal identifying information will NEVER be reported publicly.

If you choose to participate in Together We Cann, you will contribute to an effort aimed at improving the medical cannabis program in Iowa. By participating, you have the opportunity to help fellow patients, inform policy change, and move the Iowa Medical Cannabis Program forward.

We sincerely appreciate you contributing your data and experiences to the Together We Cann program.

With your help, we can improve the program for all patients.

Sincerely,

Rebecca Lucas
MedPharm Iowa Research Lead

TOGETHER WE CANN

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INSTRUCTIONS

BE ACCURATE

Whether recording in paper or online, it is important that the information you record be as accurate as possible. Therefore, you should fill out each journal entry on that day. For example, enter your information for January 1, 2019 on January 1st. Do not wait several days and then fill out previous dates from memory.

BE THOROUGH

It is important that the information you record here be as complete as possible. The journal is designed with a medication table for current medications and doses to be completed every 30 days. The journal has space for one entry to be used per day. If you find this is not enough room for you, you may use two entries per day, but please date them appropriately.

BE TIMELY

Journals should be filled out when at appropriate wait times after medication has been taking, to ensure that medication is absorbed at the time of journaling, for example, 1-3 hours after a capsule. Please remember to write legibly and clearly.

RETURN WHEN FINISHED

When you near completion of the journal, you may return it to a MedPharm Iowa dispensary for data collection procedures and you will be issued a new journal.
If you have any questions about the diary, please contact a MedPharm Iowa dispensary.

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Date: _____(mm/dd/yyyy)

Medication Update

Please list ALL medications, supplements, nutraceuticals, vitamins, and herbal products you are currently taking.

Product	Dose (mg)	Frequency	Condition being treated

PRODUCT # (TOTAL DOSE VOLUME)
Find the product you are using below and use the corresponding number when completing your journal.

Capsules (per single capsule)
1. Calm Capsules 20:1 | 20mg CBD:1mg THC
2. Comfort Capsules 1:20 | 0.25mg CBD:5mg THC
3. Comfort Capsules 1:20 | 0.5mg CBD:10mg THC
4. Comfort Capsules 1:20 | 1mg CBD:20mg THC
5. Harmony Capsules 1:1 | 5mg CBD:5mg THC
6. Harmony Capsules 1:1 | 10mg CBD:10mg THC

Tincture (per 0.25ml dose)
7. Calm Tincture 20:1 (Pediatric) | 5mg CBD:0.25mg THC
8. Calm Tincture 20:1 | 25mg CBD:1.25mg THC
9. Comfort Tincture 1:20 | 0.25mg CBD:5mg THC
10. Harmony Tincture 1:1 | 5mg CBD:5mg THC

Cream (per gram)
11. Soothe Cream 2:1 | 7.5mg CBD:3.75mg THC

Date: _____ (mm/dd/yyyy) **Time Taken:** _____(AM/PM)

Product Used: _____ (Enter product number found in instructions)

Dose: _____ Number of capsules _____Tincture in milliliters ☐ Cream

Symptom Severity AFTER Medication?

After taking your cannabis medicine, how are your symptoms?
Enter a number (1-10) next to your symptoms. Higher = more severe.
(0 = not interfering with life, 10 = substantially interfering with life)

	Chronic pain
	Lack of appetite
	Nausea and/or vomiting
	Muscle spasms

	Muscle spasticity
	Tremors
	Insomnia
	Seizures

	Neuropathy / Nerve Pain
	Anxiety
	Self injurious behavior
	Other:

Side Effects of Cannabis Medication (if any). Please select all that apply.

	Dry mouth
	Fatigue
	Fogginess
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	Dizziness
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	Diarrhea

	Sleepiness
	Euphoria
	Difficulty concentrating
	Rapid heart beat
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	Rapid heart beat
	Other:

Date: _____ (mm/dd/yyyy) **Time Taken:** _____(AM/PM)

Product Used: _____ (Enter product number found in instructions)

Dose: _____ Number of capsules _____Tincture in milliliters ☐ Cream

Symptom Severity AFTER Medication?

After taking your cannabis medicine, how are your symptoms?
Enter a number (1-10) next to your symptoms. Higher = more severe.
(0 = not interfering with life, 10 = substantially interfering with life)

	Chronic pain
	Lack of appetite
	Nausea and/or vomiting
	Muscle spasms

	Muscle spasticity
	Tremors
	Insomnia
	Seizures

	Neuropathy / Nerve Pain
	Anxiety
	Self injurious behavior
	Other:

Side Effects of Cannabis Medication (if any). Please select all that apply.

	Dry mouth
	Fatigue
	Fogginess
	Headache

	Dizziness
	Anxiety
	Pain
	Diarrhea

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Date: _____(mm/dd/yyyy)

Notes

Please note any changes in medication, supplements, nutraceuticals, vitamins, and herbal products you are currently taking. Please write the date of any noted changes or events.