



## **BASELINE SURVEY** **3 Month Follow Up**

Thank you for taking the time to fill out this follow-up survey!

This survey will take about 30 minutes to complete and has a total of 5 sections.

Please try to complete the survey in one sitting, answering each question as honestly as possible.

All of your answers will be kept confidential.



Consortium for  
Medical Marijuana  
Clinical Outcomes Research

Note: This printed survey is for reference only and is not intended for participant use.

## SECTION 1: GENERAL HEALTH

*First, we will ask a few questions about your health. Some of these questions will be similar to the ones we asked during your baseline survey a few months ago.*

**A1.** Overall, how would you rate your health in the **past 4 weeks**?

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

**A2.** During the **past 4 weeks**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do physical activities

**A3.** During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

- None at all
- A little bit
- Some
- Quite a lot
- Could not do daily work

**A4.** How much bodily pain have you had in the **past 4 weeks**?

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

**A5.** During the **past 4 weeks**, how much energy did you have?

- Very much
- Quite a lot
- Some
- A little
- None

**A6.** During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do social activities

**A7.** During the **past 4 weeks**, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

- Not at all
- Slightly
- Moderately
- Quite a lot
- Extremely

**A8.** During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do daily activities

**A9-A12.**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting such that, in the <u>past 30 days</u> , you...	Yes	No
Have had nightmares about it or thought about it when you did not want to?	<input type="checkbox"/>	<input type="checkbox"/>
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	<input type="checkbox"/>	<input type="checkbox"/>
Were constantly on guard, watchful, or easily startled?	<input type="checkbox"/>	<input type="checkbox"/>
Felt numb or detached from others, activities, or your surrounding?	<input type="checkbox"/>	<input type="checkbox"/>

**A13.** How would you rate your sleep quality during the past 30 days?

- Very good
- Fairly good
- Fairly bad
- Very bad

**A14-A21.**

Over the <u>past 2 weeks</u> , how often have you been bothered by any of the following problems?	Not At All	Several Days	Over Half the Days	Nearly Every Day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling asleep, staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself – or that you’re a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A22-A28.**

Over the <u>past 2 weeks</u> , how often have you been bothered by the following problems?	Not At All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it's hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**A29. If A4="None",** Have you had any pain other than minor everyday kind of pain in **past 24 hours**?

Yes

No → **Skip to Question A34**

**A30-A33.** Please use the scale below and choose the answers that best describe your pain in the **past 24 hours**.

Rate your pain in <u>past 24 hours</u> :	No Pain ←————→ As bad as you can imagine										
	0	1	2	3	4	5	6	7	8	9	10
At its WORST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its LEAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On AVERAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RIGHT NOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**A34-A37.** In the table below, we would like to know how much if at all pain interfered with any aspect of your life in the **past 7 days**.

In the <u>past 7 days</u> ...	Not At All	A Little Bit	Somewhat	Quite A Lot	Very Much
How much did pain interfere with your day-to-day activities?	<input type="checkbox"/>				
How much did pain interfere with work around the home?	<input type="checkbox"/>				
How much did pain interfere with your ability to participate in social activities?	<input type="checkbox"/>				
How much did pain interfere with your household chores?	<input type="checkbox"/>				

**A38-A54.** People have a lot of different feelings. Please tell us how much if at all you've experienced the following feelings in the **past 7 days**.

In the <u>past 7 days</u> ...	Not At All	A Little Bit	Somewhat	Quite A Lot	Very Much
I felt cheerful	<input type="checkbox"/>				
I felt attentive	<input type="checkbox"/>				
I felt delighted	<input type="checkbox"/>				
I felt happy	<input type="checkbox"/>				
I felt joyful	<input type="checkbox"/>				
I felt enthusiastic	<input type="checkbox"/>				
I felt determined	<input type="checkbox"/>				
I felt interested	<input type="checkbox"/>				
I was thinking creatively	<input type="checkbox"/>				
I liked myself	<input type="checkbox"/>				
I felt peaceful	<input type="checkbox"/>				
I felt good-natured	<input type="checkbox"/>				
I felt useful	<input type="checkbox"/>				
I felt understood	<input type="checkbox"/>				
I felt content	<input type="checkbox"/>				
I felt energetic	<input type="checkbox"/>				
I felt motivated	<input type="checkbox"/>				

**A55-A61.** People have a lot of different feelings. Please tell us how often you've experienced the following feelings in the **past 7 days**.

In the <b>past 7 days</b> ...	Never	Rarely	Sometimes	Often	Always
I was irritated more than people knew.	<input type="checkbox"/>				
I felt angry.	<input type="checkbox"/>				
I felt like I was ready to explode.	<input type="checkbox"/>				
I was grouchy.	<input type="checkbox"/>				
I felt annoyed.	<input type="checkbox"/>				
I felt fearful.	<input type="checkbox"/>				
I felt suffering.	<input type="checkbox"/>				

## SECTION 2: ALCOHOL, AND OTHER DRUG USE

*Now we will ask about your use of alcohol or other substances.*

**B1.** In the **past 3 months**, how often did you have a drink containing alcohol?

- Never —————> **Skip to question B4**
- Monthly or Less
- 2-4 Times a Month
- 2-3 Times a Week
- 4 or More Times a Week

**B2.** On a typical day that you consumed alcohol in the **past 3 months**, how many standard drinks did you have?

- 1 or 2
- 3 to 4
- 5 to 6
- 7 to 9
- 10 or More

**B3.** In the **past 3 months**, how often did you have six or more drinks on one occasion?

- Daily or Almost Daily
- Weekly
- Monthly
- Less than Monthly
- Never

**B4.** Do you now smoke cigarettes every day, some days, or not at all?

- Every Day
- Some Days
- Not At All
- Don't Know/Not Sure
- Prefer Not to Answer

**B5. If B4 = "Every Day" or "Some Days",** During the **past 3 months**, have you stopped smoking for one day or longer because you were trying to quit smoking?

- Yes
- No
- Don't Know/Not Sure
- Prefer Not to Answer

**B6.** Have you ever used an e-cigarette or other electronic vaping product, even just one time, in your entire life?

- Yes
- No
- Don't Know/Not Sure
- Prefer Not to Answer

**B7. If B6 = "Yes",** do you now use e-cigarettes or other electronic vaping products every day, some days, or not at all?

- Every Day
- Some Days
- Not At All
- Don't Know/Not Sure
- Prefer Not to Answer

**B8-B17**

How often have you used the following substances in the <u>past 30 days</u> ?	Not At All	1-2 Times	About Once a Week	About Once a Day	Several Times a Day
Opioids (e.g., Oxycontin, Vicodin, Percocet, Fentanyl) <b>With a Prescription</b>	<input type="checkbox"/>				
Opioids (e.g., Oxycontin, Vicodin, Percocet, Fentanyl, Heroin) <b>Without a Prescription</b>	<input type="checkbox"/>				
Amphetamines (e.g., Speed/Methamphetamine) <b>With a Prescription</b>	<input type="checkbox"/>				
Amphetamines (e.g., Speed/Methamphetamine) <b>Without a Prescription</b>	<input type="checkbox"/>				
Benzodiazepines (e.g., Xanax, Valium, Ativan) <b>With a Prescription</b>	<input type="checkbox"/>				
Benzodiazepines (e.g., Xanax, Valium, Ativan) <b>Without a Prescription</b>	<input type="checkbox"/>				
Cocaine or Crack Cocaine	<input type="checkbox"/>				
Hallucinogens (e.g., LSD, PCP, Ecstasy or MDMA)	<input type="checkbox"/>				
Synthetic Marijuana (K2, Spice)	<input type="checkbox"/>				
Kratom	<input type="checkbox"/>				

## SECTION 3: MEDICAL MARIJUANA USE

Next, we will ask about your *medical/dispensary marijuana use*.

By “*medical marijuana*” we mean marijuana that was obtained from a dispensary using your medical marijuana card

**C1.** We understand that you started to use medical marijuana in the **past 3 months**.

Are you still using it?

- Yes —————> **Skip to Question C10**
- No

**C2-C9.** If C1 = “No”, What are your main reasons for stopping your medical marijuana use? Please select all that apply.

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- Job Requirements or Legal Barriers (e.g. public services, for my job, etc.)
- It Didn’t Work/Never Found a Product that Worked Well
- I Am Worried How Medical Marijuana Might Interfere with my Other Medications
- Other (Please Specify):  
\_\_\_\_\_

**C10.** If C1 = “Yes”, Are you thinking about stopping your medical marijuana use?

- Yes
- No —————> **Skip to Question C20**

**C11-C18.** What are your main reasons for wanting to stop your medical marijuana use? Please select all that apply.

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- Job Requirements or Legal Barriers (e.g. public services, for my job, etc.)
- It Didn’t Work/Never Found a Product that Worked Well
- I Am Worried How Medical Marijuana Might Interfere with my Other Medications
- Other (Please Specify):  
\_\_\_\_\_

**C19.** If C1 = “Yes”, How long have you been using medical marijuana?

- Less Than 1 Month
- 1 Month
- More Than 1 Month but Less Than 3 Months
- 3 Months
- More Than 3 Months

**C20.** If C10 = “No”, How long did you use medical marijuana before you stopped?

- Less Than 1 Month
- 1 Month
- More Than 1 Month but Less Than 3 Months
- 3 Months
- More Than 3 Months

**C21-C29.**

Which of the following marijuana products have you tried?	(Check all that apply)
Flower (e.g., “Bud”, “Weed”, Cannabis)	<input type="checkbox"/>
Vaporizer Cartridges or Vape Pen (Liquid, NOT Flower)	<input type="checkbox"/>
Concentrates (for Vaping or Smoking), such as Shatter, Rosin, Wax, Kief, or Crumble	<input type="checkbox"/>
Topical: Ointments, Gels, Patches, or Creams	<input type="checkbox"/>
Oral Tinctures (with a Dropper)	<input type="checkbox"/>
Oral Concentrates (such as Distillate Syringe or RSO Syringe)	<input type="checkbox"/>
Oral Capsules or Edibles (Chews, Lozenges, Chocolates, or Gels)	<input type="checkbox"/>
Other (Please Specify) (e.g., Inhalers, Suppositories) : _____	<input type="checkbox"/>

If **FLOWER** was selected:

*These next few questions will ask about your use of marijuana flower.*

**C30.** Have you used Flower in the **past 30 days**?

- Yes  
 No

**C31-C38.** If “No”, What are some of the main reasons you haven’t used flower?

- Cost  
 Side Effects  
 No Longer Need It  
 Physician Advice or Recommendation  
 It Didn’t Work  
 Other (Please Specify): \_\_\_\_\_

**C39-C44.** How often have you used the following methods to consume **marijuana flower** in the **past 30 days**?

	Never	Less Than Weekly	1-3 Times a Week	4-6 Times a Week	Every Day	Several Times a Day
Smoked Using Bowl, Pipe, One-Hitter	<input type="checkbox"/>					
Smoked as Joint or Pre-Roll	<input type="checkbox"/>					
Smoked as Blunt	<input type="checkbox"/>					
Smoked Using Water Pipe or Bong	<input type="checkbox"/>					
Vaped Using Dry Vaporizer (Volcano, Argo, etc.)	<input type="checkbox"/>					
Cooked Into Edibles	<input type="checkbox"/>					

**C45.** On a typical or average day that you smoke or vape **flower**, how many times a day do you use it? *Note that if you consume more on some days than others, give the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C46.** On average, how many hits, tokes, or puffs do you take per session that you smoke or vape flower?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C47.** On average, how many seconds do you inhale with each hit/puff when you smoke or vape flower?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C48.** How long would it take you to go through one flower container of 1/8 oz (3.5 grams), if you did not share with anyone?

- 1 Day (or Less)
- About Half a Week
- 1 Week
- 2 Weeks
- 3-4 Weeks
- A month or More

**C49.** On average, how many 1/8 oz flower containers do you use per month? Do not count those you did not use, or those you shared or wasted?

- 1
- 2
- 3
- 4
- 5
- 6-10
- 11-20
- 21-30
- 31-40
- 41-50

**C50.** On average, what is the THC concentration of the flower you typically use?

- Less than 5%
- 5%-10%
- 10%-15%
- 15%-20%
- 20%-25%
- 25%-30%
- More than 35%
- Don't Know/Not Sure

**C51.** Approximately how long does it take for you to feel the effect after using Flower?

- Less than 5 Minutes
- 5-15 Minutes
- 16-30 Minutes
- 31-60 Minutes
- 1-2 Hours
- More than 2 Hours
- Not Sure

**C52.** About how long does the effect you get from using flower last for you?

- 15-30 Minutes
- 30-60 Minutes
- 1-3 Hours
- 3-6 Hours
- 6-12 Hours
- 12-24 Hours
- More than a Day
- I Feel It All the Time
- Not Sure

**C53.** Flower products can include both CBD and THC. What is the type of flower you use the most?

- CBD Only
- Primarily CBD (e.g., 4:1, 20:1 CBD:THC Ratio)
- Primarily THC (e.g., 1:20, 1:4 CBD:THC Ratio)
- THC Only
- I Don't Know

**C54.** Approximately how many different strains of flower have you tried since joining the Florida medical marijuana program?

- 1
- 2
- 3-5
- 6-10
- 10-20
- 20-50
- 50 or More
- Not Sure, or Not Applicable

**C55-C58.** Which type of flower do you use the most? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**If VAPE was selected:**

*These next few questions will ask about your use of marijuana vape cartridges.*

**C59.** Have you used vape cartridges in the **past 30 days**?

- Yes
- No

**C60-C66.** If **"No"**, What are some of the main reasons you haven't used flower?

- Cost
  - Side Effects
  - No Longer Need It
  - Physician Advice or Recommendation
  - It Didn't Work
  - Other (Please Specify):
- 

**C67.** How often have you vaped medical marijuana (liquid NOT flower) using a vape cartridge in the **past 30 days**?

- Less Than Weekly
- 1-3 Times a Week
- 4-6 Times a Week
- Everyday

**CONTINUE TO NEXT PAGE >**

**C68.** On a typical or average day that you smoke or vape, how many times a day do you use it? *Note that if you consume more on some days than others, give the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C69.** On average, many hits, tokes, or puffs do you take per occasion that you vape?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10                       |
| <input type="checkbox"/> |

**C70.** On average when you vape, how many seconds do you inhale with each hit, toke, or puff?

- |   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

**C71.** Approximately how long does it take to feel the effect after using your vape pen?

- Less than 5 Minutes
- 5-15 Minutes
- 16-30 Minutes
- 31-60 Minutes
- 1-2 Hours
- More than 2 Hours
- Not Sure

**C72.** About how long does the effect of hitting a vape pen last?

- 15-30 Minutes
- 30-60 Minutes
- 1-3 Hours
- 3-6 Hours
- 6-12 Hours
- 12-24 Hours
- More than a Day
- I Feel It All the Time
- Not Sure

**C73.** Some vape cartridges include both CBD and THC. Which type of vape cartridge do you use most often?

- CBD Only
- Primarily CBD (e.g., 4:1, 20:1 CBD:THC Ratio)
- Primarily THC (e.g., 1:20, 1:4 CBD:THC Ratio)
- THC Only
- I Don't Know

**C74.** Approximately how many different types/strains of vapes have you tried since joining the Florida medical marijuana program?

- 1
- 2
- 3-5
- 6-10
- 10-20
- 20-50
- 50 or More
- Not Sure, or Not Applicable

**C75-C78.** Which strain type do you use most often in the vape cartridge? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**CONTINUE TO NEXT PAGE >**

**If concentrates for smoking/vaping (non-liquid concentrates) were selected:**

*These next few questions ask about your use of concentrates for smoking or vaping (non-liquid concentrates)*

**C79.** Have you used concentrates in the **past 30 days**?

- Yes
- No

**C80-C86.** If “No”, What are some of the main reasons you haven’t used concentrates?

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- It Didn't Work
- Other (Please Specify): \_\_\_\_\_

**C87-C94.** How often have you used each of the following types of concentrates for smoking or vaping in the **past 30 days**:

	Never	Less Than Weekly	1-3 Times a Week	4-6 Times a Week	Every Day	Several Times a Day
Shatter	<input type="checkbox"/>					
Rosin	<input type="checkbox"/>					
Wax	<input type="checkbox"/>					
Kief	<input type="checkbox"/>					
Crumble	<input type="checkbox"/>					
Dab Tab	<input type="checkbox"/>					
Hash	<input type="checkbox"/>					
RSO/Distillate Syringe	<input type="checkbox"/>					

**C95.** On a typical or average day that you smoke or vape concentrates, how many times a day do you smoke or vape concentrates?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C96.** On average, many hits or puffs do you take per session that you smoke or vape concentrates?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C97.** If you smoke or vape concentrates, how many seconds do you inhale with each hit/puff?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C98.** How often do you consume at least 25 mg (a “rice-sized” piece or dab) of smoked or vaped concentrate?

- Never
- Monthly or Less
- 2-4 Times a Month
- 2-3 Times a Week
- 4-6 Times a Week
- Every Day

**C99.** Approximately how long does it take to feel the effect after consuming your concentrate?

- Less than 5 Minutes
- 5-15 Minutes
- 16-30 Minutes
- 31-60 Minutes
- 1-2 Hours
- More than 2 Hours
- Not Sure

**C100.** About how long does the effect of smoking or vaping a concentrate last?

- 15-30 Minutes
- 30-60 Minutes
- 1-3 Hours
- 3-6 Hours
- 6-12 Hours
- 12-24 Hours
- More than a Day
- I Feel It All the Time
- Not Sure

**C101.** What is the percentage of THC in the concentrate that you smoke/vape the most?

- Less than 30%
- 31%-40%
- 41%-50%
- 51%-60%
- 61%-70%
- 71%-80%
- More than 80%
- Don't Know/Not Sure

**C102.** Approximately how many different strains or types of concentrates have you tried since joining the Florida medical marijuana program?

- 1
- 2
- 3-5
- 6-10
- 10-20
- 20-50
- 50 or More
- Not Sure, or Not Applicable

**C103-C106.** Which strain type do you use the most in concentrates that you smoke or vape? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**If topical was selected:**

*These next few questions will ask about your use of topical marijuana products*

**C107.** Have you used topicals in the **past 30 days?**

- Yes
- No

**C108-C114.** **If “No”**, What are some of the main reasons you haven't used topicals?

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- It Didn't Work
- Other (Please Specify):

\_\_\_\_\_

**C115-C120.** How often have you used each of the following types of topicals in the **past 30 days**:

	Never	Less Than Weekly	1-3 Times a Week	4-6 Times a Week	Every Day	Several Times a Day
Patch	<input type="checkbox"/>					
Cream or Lotion	<input type="checkbox"/>					
Balm or Salve	<input type="checkbox"/>					
Spray	<input type="checkbox"/>					
Transdermal Gel	<input type="checkbox"/>					

**C121.** On a typical or average day that you apply topical products, how many times a day do you apply it? *Note that if you use more some days than others, we are still looking for the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C122.** Approximately how long does it take to feel the effect after using your topical product?

- Less than 5 Minutes
- 5-15 Minutes
- 16-30 Minutes
- 31-60 Minutes
- 1-2 Hours
- More than 2 Hours
- Not Sure

**C123.** About how long does the effect of the topical last?

- 15-30 Minutes
- 30-60 Minutes
- 1-3 Hours
- 3-6 Hours
- 6-12 Hours
- 12-24 Hours
- More than a Day
- I Feel It All the Time
- Not Sure

**C124.** Some topical products include both CBD and THC. What is the type of topical you use most often?

- CBD Only
- Primarily CBD  
(e.g., 4:1, 20:1 CBD:THC Ratio)
- Primarily THC  
(e.g., 1:20, 1:4 CBD:THC Ratio)
- THC Only
- I Don't Know

**C125.** Approximately, how many different types/strains of topical products have you tried since joining the Florida medical marijuana program?

- 1
- 2
- 3-5
- 6-10
- 10-20
- 20-50
- 50 or More
- Not Sure, or Not Applicable

**C126-C129.** Which strain type do you use the most in your topical products? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**If oral tinctures (with a dropper) were selected:**

*These next few questions will ask about your use of oral tinctures (with a dropper)*

**C130.** Have you used oral tinctures in the **past 30 days**?

- Yes
- No

**C131. If “No”,** What are some of the main reasons you haven’t used oral tinctures in the **past 30 days**? (Please check all that apply)?

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- It Didn't Work
- Other (Please Specify): \_\_\_\_\_

**C132.** How often have you used oral tinctures with a dropper in the **past 30 days**?

- Less Than Weekly
- 1-3 Times a Week
- 4-6 Times a Week
- Every Day

**C133.** On a typical or average day that you use oral tinctures, how many times a day do you use it? *Note that if you take more some days than others, we are still looking for the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C134.** On average, how many milliliters do you consume per occasion that you use a tincture?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C135-136.** On average when using your tincture, how much THC and/or CBD do you consume each time?

	Less Than 5mg	5mg	10mg	15mg	25mg	30mg	50mg	100mg	More Than 100mg	Don't Know
E5. THC	<input type="checkbox"/>									
E6. CBD	<input type="checkbox"/>									

**C137.** Approximately how long does it take to feel the effect after using your tincture?

- |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Less Than 5 Min          | 5-15 Min                 | 16-30 Min                | 31-60 Min                | 1-2 Hr                   | More Than 2 Hr           | Not Sure                 |
| <input type="checkbox"/> |

**C138.** About how long does the effect of the tincture last?

- 15-30 Minutes
- 30-60 Minutes
- 1-3 Hours
- 3-6 Hours
- 6-12 Hours
- 12-24 Hours
- More than a Day
- I Feel It All the Time
- Not Sure

**C139.** Some tinctures include both THC and CBD. What is the type of tincture you use the most?

- CBD Only
- Primarily CBD (e.g., 4:1, 20:1 CBD:THC Ratio)
- Primarily THC (e.g., 1:20, 1:4 CBD:THC Ratio)
- THC Only
- I Don't Know

**C140.** Approximately how many different types/strains of tincture from the Florida MMJ program have you tried since joining the program?

- 1
- 2
- 3-5
- 6-10
- 10-20
- 20-50
- 50 or More
- Not Sure, or Not Applicable

**C141.** Which strain type do you use the most in tinctures? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**If oral concentrates (e.g., distillate syringe or RSO syringe) were selected:**

*These next few questions will ask about your use of oral concentrates (e.g., distillate syringe or RSO syringe)*

**C142.** Have you used oral concentrates in the **past 30 days**?

- Yes
- No

**C143.** If “No”, What are some of the main reasons you haven't used oral concentrates in the **past 30 days**? (Please check all that apply?)

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- It Didn't Work
- Other (Please Specify):

**C144-C145.** How often have you used oral concentrates using the following methods in **past 30 days**:

Distillate Syringe	RSO Syringe
Never <input type="checkbox"/>	Never <input type="checkbox"/>
Less than Weekly <input type="checkbox"/>	Less than Weekly <input type="checkbox"/>
1-3 Times a Week <input type="checkbox"/>	1-3 Times a Week <input type="checkbox"/>
4-6 Times a Week <input type="checkbox"/>	4-6 Times a Week <input type="checkbox"/>
Every Day <input type="checkbox"/>	Every Day <input type="checkbox"/>
Several Times a Day <input type="checkbox"/>	Several Times a Day <input type="checkbox"/>

**C146.** On a typical average day that you take oral concentrates, how many times per day do you use oral concentrates? *Note that if you take more some days than others, we are still looking for the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C147.** On average, how much of oral concentrate do you take per occasion?

- 1 rice-sized grain
- 2 rice-sized grains
- 3 rice-sized grains
- 4 or more rice-sized grains

**C148.** Approximately how long does it take to feel the effect after using your oral concentrate?

- |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Less Than 5 Min          | 5-15 Min                 | 16-30 Min                | 31-60 Min                | 1-2 Hr                   | More Than 2 Hr           | Not Sure                 |
| <input type="checkbox"/> |

**C149.** About how long does the effect of the oral concentrate last?

- |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 30-60 Min                | 1-3 Hr                   | 3-6 Hr                   | 6-12 Hr                  | 12-24 Hr                 | More Than a Day          | I Feel It All the Time   | Not Sure                 |
| <input type="checkbox"/> |

**C150.** Some oral concentrates include both THC and CBD. What is the type of oral concentrate you use the most?

- CBD Only
- Primarily CBD (e.g., 4:1, 20:1 CBD:THC Ratio)
- Primarily THC (e.g., 1:20, 1:4 CBD:THC Ratio)
- THC Only
- I Don't Know

**C151.** Approximately how many different types or strains of oral concentrate have you tried since joining the Florida medical marijuana program?

- |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3-5                      | 6-10                     | 10-20                    | 20-50                    | 50 or More               | Not Sure, or N/A         |
| <input type="checkbox"/> |

**C152.** What strain type do you use the most in oral concentrate? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**If oral capsules/edibles were selected:**

*These next few questions will ask about your use of oral capsules/edibles*

**C153.** Have you used edibles/capsules in the **past 30 days**?

- Yes
- No

**C154. If “No”,** What are some of the main reasons you haven’t used edibles/capsules?

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- It Didn’t Work
- Other (Please Specify): \_\_\_\_\_

**C155-C157.** How often have you used the following oral methods in the **past 30 days**:

	Never	Less Than Weekly	1-3 Times a Week	4-6 Times a Week	Every Day	Several Times a Day
Capsules/Tablets	<input type="checkbox"/>					
Gel/Gummies	<input type="checkbox"/>					
Brownie/Cookie	<input type="checkbox"/>					

**C158.** On a typical or average day that you take capsules/edibles, how many times per day do you use capsules or edibles? *Note that if you use more some days than others, we are still looking for the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C159-C160.** On average, when taking capsules or edibles how much THC and/or CBD do you consume each time?

	Less Than 5mg	5mg	10mg	15mg	25mg	30mg	50mg	100mg	More Than 100mg	Don’t Know
G4. THC	<input type="checkbox"/>									
G5. CBD	<input type="checkbox"/>									

**C161.** Approximately how long does it take to feel the effect after consuming your capsule or edibles?

- |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Less Than 5 Min          | 5-15 Min                 | 16-30 Min                | 31-60 Min                | 1-2 Hr                   | More Than 2 Hr           | Not Sure                 |
| <input type="checkbox"/> |

**C162.** About how long does the effect of the capsule/edible last?

- |                          |                          |                          |                          |                          |                          |                              |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|
| 30-60<br>Min             | 1-3 Hr                   | 3-6 Hr                   | 6-12 Hr                  | 12-24 Hr                 | More<br>Than a<br>Day    | I Feel It<br>All the<br>Time | Not Sure                 |
| <input type="checkbox"/>     | <input type="checkbox"/> |

**C163.** Some capsules/edibles include both THC and CBD. What is the type of oral concentrate you use the most?

- CBD Only
- Primarily CBD (e.g., 4:1, 20:1 CBD:THC Ratio)
- Primarily THC (e.g., 1:20, 1:4 CBD:THC Ratio)
- THC Only
- I Don't Know

**C164.** Approximately how many different types/strains of capsules/edibles have you tried since joining the Florida medical marijuana program?

- 1
- 2
- 3-5
- 6-10
- 10-20
- 20-50
- 50 or More
- Not Sure, or Not Applicable

**C165.** Which strain type do you use the most in capsules/edibles? (Choose all that apply)

- Indica
- Sativa
- Hybrid
- I Don't Know

**If "Other" selected in #C21**

Now we will ask you some questions about your use of "Other" products tried.

**C166.** Is the product:

- An Inhaler
- A Rectal Suppository
- A Sublingual Spray
- Other (Please Specify): \_\_\_\_\_

**C167.** How often have you used this product in the **past 30 days**?

- Never
- Less than Weekly
- 1-3 Times a Week
- 4-6 Times a Week
- Every Day

**C168. If C167 = "Never",** What are some of the main reasons you haven't used oral concentrates in the **past 30 days**? (Please Check All That Apply)

- Cost
- Side Effects
- No Longer Need It
- Physician Advice or Recommendation
- It Didn't Work
- Other (Please Specify): \_\_\_\_\_

**C169.** On a typical day that you use this product, how many times per day do you use it? *Note that if you use more on some days than others, we are still looking for the average number of times across a typical day.*

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        | 10 or More               |
| <input type="checkbox"/> |

**C170.** Overall, have you found a specific method of using medical marijuana and/or a product type or strain that you prefer?

- Yes
- No

**C171. If "Yes",** what method of using medical marijuana do you prefer? (Check All That Apply)

- Flower
- Vape
- Concentrate (Smoking)
- Tincture
- Topical
- Oral Concentrate
- Capsule/Edible
- Other
- None of These

**C172.** Please enter the strain or product name you prefer overall (if any):

\_\_\_\_\_

**C173.** Overall, how much of the marijuana that you used in the past month was from Florida dispensaries?

- |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0%                       | 10%                      | 20%                      | 30%                      | 40%                      | 50%                      | 60%                      | 70%                      | 80%                      | 90%                      | 100%                     |
| <input type="checkbox"/> |

## SECTION 4: MEDICAL MARIJUANA & HEALTH

Now we will ask about your health, medical marijuana, and what products you have found most effective (if any).

**D1-D27.** [Only Health Conditions indicated in Baseline Survey will display.] You indicated being diagnosed with the following health conditions. How has medical marijuana affected each of your conditions or symptoms?

Health Condition	How has medical marijuana affected each of your conditions or symptoms?
Anxiety	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Depression	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Attention-Deficit/Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Bipolar disorder	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Schizophrenia	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Insomnia/sleeping problems	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Migraine/Headaches	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure

Fibromyalgia	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Chronic Pain	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Cancer	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Asthma	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Chronic Lung Disease	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
High Blood Pressure	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Heart Disease	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Diabetes	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Kidney Disease/Dialysis	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Crohn's Disease/Ulcerative Colitis	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure

Stroke	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Multiple Sclerosis (MS)	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Parkinson's Disease	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Epilepsy/Seizure disorder	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Alzheimer's Disease or Dementia	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Glaucoma	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
HIV/AIDS	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
Other (Please specify: _____)	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure
<input type="checkbox"/> None of these	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No Change <input type="checkbox"/> N/A - Unsure

[Only Health Conditions selected “Better” in previous question will display.] Please fill out this form according to the health conditions that apply to you:

Health Condition	D28-D55. For each of these conditions, have you found a specific method of using and/or a product type or strain that is most effective?	D56-D82 (If checked “yes”) What method of using medical marijuana is most effective for this condition (Check all that apply)?	D83-D108 (If checked “yes”) Please enter the name of the medical marijuana strain or product type that is most effective for each condition (e.g., “9lb hammer”, “pineapple sunset”):
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Attention-Deficit/Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>

Bipolar disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Insomnia/ sleeping problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Migraine/ Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>

Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Chronic Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Kidney Disease/ Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Crohn's Disease/ Ulcerative Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>

Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Multiple Sclerosis (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Epilepsy/ Seizure disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Alzheimer's Disease or Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>

Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>
Other (Please specify: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flower <input type="checkbox"/> Vape <input type="checkbox"/> Concentrate (Smoking) <input type="checkbox"/> Tincture <input type="checkbox"/> Topical <input type="checkbox"/> Oral Concentrate <input type="checkbox"/> Capsule/Edible <input type="checkbox"/> Other	<hr/> <hr/> <hr/>

**D109.** Is there a beneficial effect of medical marijuana on your health that you have noticed that has not been covered in this section?

- Yes
- No

**D110.** If yes, please explain the beneficial effect you have noticed:

\_\_\_\_\_

D111-D139. During the <u>past 2 weeks</u> , how much have you been bothered by any of the following? Please check all that apply.	D140-D166. Were any of these symptoms related to medical marijuana?
<input type="checkbox"/> Pounding or Racing Heart (Palpitations)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

<input type="checkbox"/> Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Increased Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Problems with Sexual Function	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Insomnia or Difficulty Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Memory Problems or Forgetfulness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Paranoid or Overly Suspicious	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Speech Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Dizziness or Light Headedness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Trouble with Balance or Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

<input type="checkbox"/> Sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Fatigue/Low Energy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Problems Driving	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Numbness or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Hot or Cold Sensations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Swelling of the Arms or Legs (Edema)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Itchy Skin or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> Other (please specify: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

**D167.** Since you started using medical marijuana, have you experienced any severe side effects when you were using medical marijuana that required an emergency room visit, seeing a physician, being hospitalized, or maybe caused you to feel extremely sick for a few hours?

- Yes
- No → **Skip to Question D188**
- Not Sure → **Skip to Question D188**

**If Yes:**

**D168.** Please briefly describe what happened: \_\_\_\_\_

**D169.** How often did you experience this side effect?

- Only once
- Rarely
- Sometimes
- Often
- Always

**D170-D172.** Were you using any of the following with medical marijuana when this happened? **Check all that apply.**

- Alcohol
- Opioids
- Other Substances (please specify: \_\_\_\_\_)
- Prescription Medications (please specify: \_\_\_\_\_)
- None

**D173.** Which mode of consumption, were you using when experiencing the side effect? **Check all that apply.**

- Flower
- Vaporizer Cartridges/Vape Pen
- Concentrates (for Vaping/Smoking), such as Shatter, Rosin, Wax, Kief, or Crumble
- Topical (such as Ointments/Gels/Patches/Creams)
- Oral Tinctures (with a Dropper)
- Oral Concentrates (such as Distillate Syringe/RSO Syringe)
- Oral Capsules/Edibles (Chews/Lozenges/Chocolates/Gels)

[QUESTIONS D167-D176 ARE REPEATED UP TO TWO MORE TIMES IF USER INDICATES MORE THAN ONE SEVERE SIDE EFFECT EXPERIENCED]

**D188-D193.** *[Only medication(s)/substance(s) indicated in Baseline Survey will display.]* When you completed the baseline survey, you indicated that you wanted to track your use of specific medications or substances. Since starting your medical marijuana treatment, please indicate how your use of that medication/substance has changed.

Medication(s)/Substance(s)	Since starting your medical marijuana treatment, please indicate how your use of each medication/substance has changed.
Medication(s) [Up to 3 Total]	<input type="checkbox"/> Increased <input type="checkbox"/> No Change <input type="checkbox"/> Decreased <input type="checkbox"/> Totally Quit <input type="checkbox"/> Not Sure
Substance(s) [Up to 3 Total]	<input type="checkbox"/> Increased <input type="checkbox"/> No Change <input type="checkbox"/> Decreased <input type="checkbox"/> Totally Quit <input type="checkbox"/> Not Sure

## SECTION 5: ADDITIONAL QUESTIONS

*Note: Some of these questions will be similar to ones you were asked previously.*

Please answer the following questions about your marijuana use. Choose the response that is most correct for you in relation to your marijuana use over the **past 3 months**.

**E1.** How often do you use marijuana?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Monthly or Less          | 2-4 Times a Month        | 2-3 Times a Week         | 4 or More Times a Week   |
| <input type="checkbox"/> |

**E2.** How many hours were you “stoned” on a typical day when you had been using marijuana?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Less than 1              | 1 or 2                   | 3 or 4                   | 5 or 6                   | 7 or More                |
| <input type="checkbox"/> |

**E3.** How often during the **past 3 months** did you find that you were not able to stop using marijuana once you had started?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Less than Monthly        | Monthly                  | Weekly                   | Daily or Almost Daily    |
| <input type="checkbox"/> |

**E4.** How often during the **past 3 months** did you fail to do what was normally expected from you because of using marijuana?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Less than Monthly        | Monthly                  | Weekly                   | Daily or Almost Daily    |
| <input type="checkbox"/> |

**E5.** How often in the **past 3 months** have you devoted a great deal of your time to getting, using, or recovering from marijuana?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Less than Monthly        | Monthly                  | Weekly                   | Daily or Almost Daily    |
| <input type="checkbox"/> |

**E6.** How often in the **past 3 months** have you had a problem with your memory or concentration after using marijuana?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Less than Monthly        | Monthly                  | Weekly                   | Daily or Almost Daily    |
| <input type="checkbox"/> |

**E7.** How often do you use marijuana in situations that could be physically hazardous, such as driving, operating machinery, or caring for children?

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Less than Monthly        | Monthly                  | Weekly                   | Daily or Almost Daily    |
| <input type="checkbox"/> |

**E8.** Have you ever thought about cutting down, or stopping, your use of marijuana?

- |                          |                                   |                               |
|--------------------------|-----------------------------------|-------------------------------|
| Never                    | Yes, but not in the past 6 months | Yes, during the past 6 months |
| <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>      |

**E9.** On average, how much did you spend on marijuana product(s) in a typical month? Your best estimation is OK.

- |                          |                          |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| \$50 or Less             | \$51-\$100               | \$101-\$200              | \$201-\$300              | \$301-\$400              | \$401-\$500              | \$501-\$600              | More than \$600          |
| <input type="checkbox"/> |

**E10.** Some people consider their reasons for marijuana use to be medical or therapeutic (e.g., treat a specific health problem or symptom). Others consider their reasons for use to be recreational (e.g., for enjoyment). Others use it for both reasons. Which of the following best describes how much of **your** marijuana use is for recreational reasons vs. medical reasons?

- |                          |                          |                                  |                          |                          |
|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|
| Completely Recreational  | Mostly Recreational      | Equally Recreational and Medical | Mostly Medical           | Completely Medical       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/> |

**CONTINUE TO NEXT PAGE >**

**E11-E19.** Please indicate how influential the following factors have been on which medical marijuana products you have tried so far:

	Not At All Influential	Slightly Influential	Somewhat Influential	Very Influential	Extremely Influential
The specific recommendations from your physician	<input type="checkbox"/>				
The recommendations from medical clinic staff	<input type="checkbox"/>				
Staff at the dispensaries	<input type="checkbox"/>				
Your previous experiences	<input type="checkbox"/>				
Recommendations from family/friends/colleagues	<input type="checkbox"/>				
Online sources (Reddit, social media, websites)	<input type="checkbox"/>				
Dispensary web sites	<input type="checkbox"/>				
Price	<input type="checkbox"/>				
Products on sale	<input type="checkbox"/>				

**E20-E23.** How much do you agree with the following statements?

	Strongly Disagree	Disagree	Neutral/ Not Sure	Agree	Strongly Agree
Marijuana products with high THC content are more effective for my conditions or symptoms	<input type="checkbox"/>				
I prefer products that are lower in THC	<input type="checkbox"/>				
CBD is important to include in my medical marijuana products	<input type="checkbox"/>				
Terpenes are important to include in my medical marijuana products	<input type="checkbox"/>				

**E24.** Are any of your other care providers (e.g., primary care physician, neurologist, gynecologist, etc.) informed about your medical marijuana use?

- Yes
- No

**E25.** Would you be interested in growing your own marijuana flower if it was legal in Florida?

- Yes
- No
- Maybe

**E26.** How concerned are you about being addicted or dependent on medical marijuana?

- Very Concerned
- Concerned
- Neither Concerned nor Unconcerned
- Unconcerned
- Very Unconcerned

**E27.** How likely are you to be taking medical marijuana in a year from now?

- Very Unlikely
- Somewhat Unlikely
- Not Sure
- Somewhat Likely
- Very Likely

**E28.** What other important topics do you think we should research that weren't covered in this survey?

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**E29.** Please check the box to confirm you have answered all the questions you intended to answer and are ready to submit your survey.

- I am ready to submit my survey.

**This is the end of the survey! Thank you for completing it!**