

## Medical Cannabis Journal

Date	Product Name:	Mode of Delivery:		Foods Taken with Product:
		<input type="checkbox"/> Smoking	Other (please specify):	
Time:		<input type="checkbox"/> Vaping		
		<input type="checkbox"/> Edible		
		<input type="checkbox"/> Pill		
		<input type="checkbox"/> Topical		
Symptoms Prior to Cannabis Use:		Positive Response:		Negative Response:

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