***Usability questionnaire of SYQE device for the Patient***

***(Translated from the Hebrew version by SV)***

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| --- | --- | --- | --- | --- |
| **Patient Initials** |  | | **Date \_\_\_/\_\_\_/\_\_\_** | |
| **Patient number** |  | **Age** | **Gender** | **Male ( ) Female ( )** |
| **Medical Center:** | | | **Department:** | |

**Please describe the usual route of cannabis administration**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Smoking/Vaporizer/Other |  | Amount of inhalations per day |  | Amount of grams per month |  |

|  |  |
| --- | --- |
| **Indications for Cannabis use**  (for example: pain, chemotherapy, palliative care, spasticity etc) |  |
| **Your regular medical therapy for this indication** |  |
| **Your SOS medication for this indication** |  |

**Medical diagnosis**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Your regular medical therapy (for all problems)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Is there a Medical Pharmacological Record during hospitalization yes ( ) no ( )**

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| --- | --- | --- | --- | --- |
| **Patient Initials** |  | **Patient Number** |  | **Date \_\_\_/\_\_\_/\_\_\_\_** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Completely Disagree  1 | Disagree  2 | Slightly disagree  3 | Neutral  4 | Slightly agree  5 | Agree  6 | Completely Agree  7 |
| 1.The instructions were clear |  |  |  |  |  |  |  |
| 2.The inhaler is comfortable to hold |  |  |  |  |  |  |  |
| 3.The Inhaler is easy to operate |  |  |  |  |  |  |  |

**If you disagree (with question 3), please detail:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Completely Disagree  1 | Disagree  2 | Slightly disagree  3 | Neutral  4 | Slightly agree  5 | Agree  6 | Completely Agree  7 |
| 4.Inhalation was easy |  |  |  |  |  |  |  |
| 5.The device lights at the end of inhalation were clear |  |  |  |  |  |  |  |
| 6. The end of inhalation was clear even with the device lights |  |  |  |  |  |  |  |
| 7. The mouthpiece was comfortable |  |  |  |  |  |  |  |
| 8. I am satisfied with the device |  |  |  |  |  |  |  |
| 9. I will want to continue using the inhaler |  |  |  |  |  |  |  |
| 10. My mood improved after the inhalation |  |  |  |  |  |  |  |
| 11. My quality of sleep has improved (since starting with the inhaler) |  |  |  |  |  |  |  |
| 12. I have felt a decrease in urge to smoke canabbis (since starting the inhaler) |  |  |  |  |  |  |  |
| 13. I have felt the euphoric effect of canabbis ("high") after inhalation |  |  |  |  |  |  |  |

**14. What could be improved in the inhaler:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**15. Further comments:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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