

MEDICATION HISTORY

PATIENT NAME: _____ **DOB:** _____

PHARMACY: _____ **PHONE #** _____

A MEDICATION HISTORY IS EXTREMELY IMPORTANT FOR UNDERSTANDING YOUR DIAGNOSIS AND IT IS HELPFUL IN FORMULATING TREATMENT RECOMMENDATIONS. THEREFORE, PLEASE FILL OUT THIS FORM WITH INFORMATION ABOUT MEDICATIONS YOU HAVE BEEN PRESCRIBED FOR PSYCHIATRIC ILLNESSES.

MEDICATION: _____ DOSAGE: _____ DATES OF TREATMENT: _____

BENEFITS: _____ SIDE EFFECTS: _____ ADDITIONAL INFO. _____

MEDICATION: _____ DOSAGE: _____ DATES OF TREATMENT: _____

BENEFITS: _____ SIDE EFFECTS: _____ ADDITIONAL INFO. _____

MEDICATION: _____ DOSAGE: _____ DATES OF TREATMENT: _____

BENEFITS: _____ SIDE EFFECTS: _____ ADDITIONAL INFO. _____

MEDICATION: _____ DOSAGE: _____ DATES OF TREATMENT: _____

BENEFITS: _____ SIDE EFFECTS: _____ ADDITIONAL INFO. _____