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Sound Family Psychiatry

Medication / Medical Self Report

Current Medication	Dose	Date Started	Effectiveness	Side Effects

1) ____
2) ____
3) ____
4) ____

Previously used psychiatric medications	Dose	Dates used	Effectiveness	Side Effects

1)____
2) ____
3) ____
4) ____

MEDICAL HISTORY/ ACTIVE MEDICAL PROBLEMS:

MEDICATION ALLERGIES: ______________________________
FOOD/ENVIRONMENTAL ALLERGIES:______________________________
NEURO/HEENT: Headaches, Head injury, Loss of consciousness, Seizures, Eye problems, Ear ache, Ringing ears, Balance problems, Dry mouth ______________________________
CARDIOVASCULAR: Heart disease, High cholesterol, Hypertension, Chest Pain, Palpitation, Murmur, Stroke, Blood Clots _________
____
RESPIRATORY: Asthma, COPD, Cough, Shortness of Breath ______________________________
GASTROINTESTINAL: GERD, Nausea, Vomiting, Diarrhea, Constipation, IBS, abdominal pain, Liver problems __________________
GENITOURINARY: Painful urination, frequent urination, blood in urine, incontinence, Kidney stones ______________________
STI: Herpes, HIV/AIDS ______________________________
ENDOCRINOLOGIC: Diabetes, thyroid problems, Menopause, PCOS ______________________________
HEMATOLOGIC: anemia, bleeding disorder, Sickle Cell Disease, Thalassemia ______________________________
MUSCULOSKELETAL: Stiffness, arthritis, tremors, fracture, chronic pain ______________________________
DERM: Acne, Rash, Bruising, Laceration, Psoriasis, Eczema ______________________________
PREGNANT/BREASTFEEDING: ______________________________
PREVIOUS PREGNANCY: ______________________________
INFERTILITY/MISCARRIAGE(S)/TERMINATION(S): ______________________________
BIRTH CONTROL METHOD (if applicable): ______________________________
SURGERIES: ______________________________
PSYCHIATRIC: ______________________________
OTHER MEDICAL PROBLEMS: ______________________________

NAME: ______________________________