MEDICATION HISTORY

PATIENT NAME:_____ DATE:_____

For our records, please list: 1) Any known allergies, 2) all medications, both over-the-counter and physician prescribed, you are taking now or have taken during the last six months, and 3) any psychiatric medications (antianxiety, antidepressant, antimanic, antipsychotic, tranquilizer) you have ever taken.

ALLERGIES: _____

_____

MEDICATION NAME	STRENGTH (mg)	DOSAGE & FREQUENCY	M.D. WHO PRESCRIBED	DATES TAKEN FROM	TO	REASON FOR TAKING	EFFECTIVENESS OR PROBLEMS