PATIENT NAME: _____
DATE OF BIRTH: _____
DATE: _____
BEST TELEPHONE # TO CONTACT YOU:_____

Please answer the following questions based on how you have felt since your last visit. You may write on the back of page to finish your answers.

Describe your moods and spirits (happy, sad, depressed, frustrated, angry or other).

Please rate your anxiety level between numbers 0 and 10, 0 being lowest and 10 being highest.

How else do you feel different mentally?

What's going well or not well with your medications?

How do the medications seem to be helping?

Has anyone worried about your alcohol or drug use?

What problems do the medications seem to be causing?

Have you had any thoughts about hurting yourself?

Are you having any dizziness or unsteadiness?

Are you seeing a doctor for anything related to your heart, circulation or blood pressure?

Are the medications, or any other factor, causing daytime sleepiness or problems with alertness?

Have other physicians, or family members, or pharmacists, expressed concerns about or raised questions about any of your medications?

What questions do you have about your current mental status?

What questions do you have about your medications?

What's your current weight?

Is there any reason to be concerned about drug or alcohol use?

Please list the name, number of times a day and dosage of all of the medicines you take: