Comprehensive Psychiatry Group, Inc.

PATIENT MEDICATION LIST

Patient Name ________________________________ Date This Form Completed ________________

LIST ALL CURRENT PRESCRIPTION MEDICATIONS

MEDICATION NAME	DOSE & DURATION	REASON PRESCRIBED	RESPONSE TO MEDICATION	PRESCRIBER	START DATE
1.					
2.					
3.					
4.					
5.					

LIST ALL CURRENT OVER THE COUNTER MEDICATION, VITAMINS, SUPPLEMENTS, NEUTRICEUTICALS, HERBALS & OTHERS

MEDICATION NAME	DOSE & DURATION	REASON PRESCRIBED	RESPONSE TO MEDICATION	START DATE
1.				
2.				
3.				
4.				

PAST PSYCHIATRIC MEDICATIONS ONLY

MEDICATION NAME	DOSE & DURATION	REASON PRESCRIBED	RESPONSE TO MEDICATION	PRESCRIBER	START DATE
1.					
2.					
3.					
4.					

Please attach a second page if additional space if needed