Medication Review Today's Date: ______________

Taking your medication daily, noticing changes in how you are feeling, and reporting to your doctor any side effects or changes in health are all essential parts of getting well. This medication review form will help you monitor your health while taking your medication.

Possible Medication Side Effects: (0= Absent, 1= Present, 2= Troublesome)

NERVOUS SYSTEM

Activation Effects

- Insomnia ( )
- Anxiety ( )
- Nervousness ( )
- Agitation ( )
- Tremor ( )

Sedation Effects

- Sleepiness ( )
- Fatigue ( )
- Weakness ( )

GASTRO-INTESTINAL SYSTEM (GI)

- Nausea ( )
- Constipation ( )
- Diarrhea ( )
- Stomach Ache ( )

SEXUAL FUNCTION

- Decreased Sexual Interest ( )
- Impotence ( )
- Ejaculation Problem ( )
- Orgasmic Difficulty ( )

OTHER SIDE EFFECTS

- Dry Mouth ( )
- Increased Sweating ( )
- Restlessness ( )
- Memory Problem ( )
- Headache ( )
- Dizziness ( )
- Visual Disturbance ( )
- Rash ( )
- Motor Tics/Twitches ( )
- Heart Palpitations ( )

Name of Current Medications and Dosing:

1. ______________________________
   Medication Dosage
2. ______________________________
   Medication Dosage
3. ______________________________
   Medication Dosage
4. ______________________________
   Medication Dosage
5. ______________________________
   Medication Dosage
6. ______________________________
   Medication Dosage
7. ______________________________
   Medication Dosage
8. ______________________________
   Medication Dosage

Any Health Changes Since Last Medication Check? Are You Taking Any New Medications?

Questions for Dr. Worsham:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Name: ______________________________ Today's Date: ____________________

PROS-D SCALE

Patient Review of Symptoms for Depression

*Circle the number and *Words that most accurately describe your experience.*

1. Sad or Depressed Mood

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

2. No Interest In Activities*/People*

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

3. Feeling Guilty*/Worthless*

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

4. Energy Problem (Tiredness*/Fatigue*)

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

5. Concentration Difficulty

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

6. Eating More*/Less*

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

7. Feeling Physically Tense*/Anxious*/Slowed Down*

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

8. Sleeping Too Much*/Too Little*/Poorly*

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

9. Thoughts About Suicide*/Death*

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4

10. Somatic Symptoms (Physical Aches*/Pains*)

Absent	Mild	Moderate	Severe	Extreme
0	1	2	3	4