

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. _____ | 2. _____ |
| Medication Dosage | Medication Dosage |
| 3. _____ | 4. _____ |
| Medication Dosage | Medication Dosage |
| 5. _____ | 6. _____ |
| Medication Dosage | Medication Dosage |
| 7. _____ | 8. _____ |
| Medication Dosage | 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