

Medical and Medication History

Northwest Psychiatric Associates Ltd. (NWPA) | 9979 Wingham Blvd, Suite 204, O'Fallon, MO 63368 | 636-695-4554

Patient name: _____ Date: _____ Date of birth: _____

This worksheet is optional and is not required for your first visit. Completing it before your appointment may help your provider review your medications, medical history, and treatment background.

Allergies or adverse reactions:

Medication / substance: _____ Reaction: _____

Medication / substance: _____ Reaction: _____

Medication / substance: _____ Reaction: _____

Current medical conditions:

Past surgeries, hospitalizations, or major medical events:

Past psychiatric treatment, hospitalizations, or higher levels of care:

Family psychiatric or medical history you think may be important:

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Current medication list

Please include prescription medications, over-the-counter medications, vitamins, supplements, injections, and as-needed medications.

Medication name: _____ Dose: _____ Prescriber: _____
Reason taken: _____ Start date/approx: _____ Still taking? Yes [] No []

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Reason taken: _____ Start date/approx: _____ Still taking? Yes [] No []

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How I currently take my medications

This page can help your provider understand your daily medication routine. Include medications you take every day and medications you take only as needed.

Morning medications:

Medication / dose: _____ Time taken: _____ How often missed? _____

Medication / dose: _____ Time taken: _____ How often missed? _____

Medication / dose: _____ Time taken: _____ How often missed? _____

Afternoon medications:

Medication / dose: _____ Time taken: _____ How often missed? _____

Medication / dose: _____ Time taken: _____ How often missed? _____

Evening / bedtime medications:

Medication / dose: _____ Time taken: _____ How often missed? _____

Medication / dose: _____ Time taken: _____ How often missed? _____

Medication / dose: _____ Time taken: _____ How often missed? _____

As-needed medications:

Medication / dose: _____ When do you take it? _____

Medication / dose: _____ When do you take it? _____

Medication side effects, concerns, or changes you want to discuss:
