Welcome to GBCC's NEW Mental Health Medication Management Program

Dear New Client,

We are looking forward to meeting you! Every effort will be made to be sensitive to your needs and assist you in the concerns that brought you here.

In order to help you, it is important for you to bring the following to your first appointment:

- ❏ Current medication list including any somatic medications, over the counter medications, herbs, supplements, dosages, and any medication allergies.
- ❏ Psychiatric medication history including responses to prior medications and approximate dates they were taken.
- ❏ Past psychiatric provider list.
- ❏ Psychiatric hospitalization history including locations, dates, and reasons for hospitalization. For recent hospitalizations, bring your discharge summary for review.
- ❏ Family mental health history including responses to medications, if known.
- ❏ Medical history including list of illnesses and surgeries.
- ❏ Most recent physical and any recent laboratory results.

We have provided you with easy to fill out forms to get you started. Additionally, the front desk staff are able to assist with retrieving records by assisting you to complete a release of information form for past hospitalizations (especially if within the past year) and for past psychiatric providers.

If you prefer you may contact your provider's directly to obtain their records.

Thank you for your cooperation and we look forward to working together with you!

Sincerely,

GBCC's Psychiatric Mental Health Nurse Practitioners

Client Name:_____DOB:____/____/____ Today's Date:____/____/____

Current Medication List

Medication Allergies:_____

Prescription Medication	Dose	Form (pill, patch, liquid)	Time of day	Use (daily or as needed)	Reason for use
Over the counter medications	Dose	Form (pill, patch, liquid)	Time of day	Use (daily or as needed)	Reason for use

Pharmacy Name: _____
Pharmacy Location:_____Pharmacy Phone:_____

Client Name:_____DOB:____/____/____ Today's Date:____/____/____

Prior Medication Trials

Medication	Reason for use	Response (effective or ineffective)	Adverse Reactions	Approximate start and stop dates

Notes:

_____

_____

_____

_____

_____

_____

Client Name:_____DOB:____/____/____ Today's Date:____/____/____

Prior Outpatient Psychiatric Mental Health Prescribers

Name	Location	Dates of Service

Psychiatric Mental Health Inpatient Hospitalizations

Hospital name	Location	Dates of Service	Reason for hospitalization

Client Name:_____DOB:____/____/____ Today's Date:____/____/____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ Heart murmur
- ❑ Crohn's disease
- ❑ High blood pressure
- ❑ Pneumonia
- ❑ Colitis
- ❑ High cholesterol
- ❑ Pulmonary embolism
- ❑ Anemia
- ❑ Hypothyroidism
- ❑ Asthma
- ❑ Jaundice
- ❑ Goiter
- ❑ Emphysema
- ❑ Hepatitis
- ❑ Cancer (type) _____
- ❑ Stroke
- ❑ Stomach or peptic ulcer
- ❑ Leukemia
- ❑ Epilepsy (seizures)
- ❑ Rheumatic fever
- ❑ Psoriasis
- ❑ Cataracts
- ❑ Tuberculosis
- ❑ Angina
- ❑ Kidney disease
- ❑ HIV/AIDS
- ❑ Heart problems
- ❑ Kidney stones

Other illnesses not listed:

_____

_____

_____

_____

Surgeries (type and year):

_____

_____

_____

_____

Client Name:_____DOB:____/____/____ Today's Date:____/____/____

FAMILY HISTORY				
	If living			**If deceased**
	Age (s)	Health, Psychiatric & Substance abuse	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

_____

_____

_____

Paternal Relatives:

_____

_____

_____