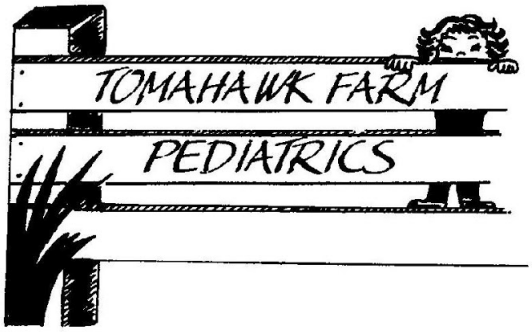

Monthly Medication Monitoring for Patients 18 Years & Older

Name: _____ **Date:** _____

Name of Medication & Dose: _____

Pharmacy (REQUIRED): _____

Have You Experienced Any of the Following:

	Yes	No
Weight Loss or Gain:		
Headache:		
Nausea:		
Vomiting:		
Depression:		
Suicidal Thoughts:		
Any Change in Sexual Activity:		
Any Sleep Disturbance:		

* Please Describe How This Medication Has Affected Your Ability to Focus:

_____

_____

_____

_____

Patient Signature: _____

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