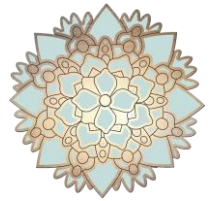


Hamzavi Psychiatry and Wellness Center PLLC
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MEDICATION REVIEW

Your questions and concerns are important to us! Please complete this form to focus our session.

Patient name (name of anyone joining you): _____

Date of Visit: _____

| Names of ALL Current Medications | Dose (mg) | Frequency (ie. Bedtime only) | Is Dr. Hamzavi the prescriber? | Refills Needed? | 90 Day Supply? |
|---|-----------|----------------------------------|-----------------------------------|--------------------|-------------------|
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- Pharmacy Name and Address for refills today: _____
- Do you forget to take your medication? How often? (# days/week): _____
- Are you having any **side effects**? If yes, how long have you noticed them? _____
- Please rate your **mood** today (1, worst to 10, best) _____ **anxiety**? (10 being worst) _____
- How many hours do you **sleep** at night? _____ Do you feel rested when you wake? _____
- Have you had any alcohol/marijuana/other drugs in the last 30 days? _____
- Have there been any changes in your medical history since your last visit? Yes _____ No _____
- **Please list up to 3 items you would like to discuss today, in order of importance:** (if you need more than your scheduled appointment, you may be asked to return to ensure all areas are addressed).
 1. _____
 2. _____
 3. _____

****Please notify staff of any insurance or contact information changes****