

Medication Management Follow-Up Questionnaire

Complete before each medication follow-up visit. Bring a current medication list and recent laboratory results when available.

Patient name:	_____	Date of birth:	_____
Date completed:	_____	Appointment date:	_____

A. Since your last appointment

Question	No	Yes	Unsure
Did you start, stop, miss, or change any psychiatric medication?	☐	☐	☐
Did another clinician start or stop a medication, supplement, or over-the-counter product?	☐	☐	☐
Did you visit an emergency department, urgent care, or hospital?	☐	☐	☐
Did you experience a fall, fainting, seizure, pregnancy, major illness, or surgery?	☐	☐	☐
Did your alcohol, cannabis, nicotine, caffeine, or other substance use change?	☐	☐	☐
Are you having trouble obtaining, paying for, or remembering medication?	☐	☐	☐

Describe the most important change since your last visit:

B. Current psychiatric medications

Medication	Dose	Time taken	Days missed since last visit	Helpful? 0–10	Side effects or concerns

C. Possible side effects

- | | |
|---|---|
| ☐ Sleepiness or fatigue | ☐ Insomnia |
| ☐ Dizziness or fainting | ☐ Restlessness or inability to sit still |
| ☐ Tremor, stiffness, or abnormal movements | ☐ Nausea, constipation, diarrhea, or appetite change |
| ☐ Weight change | ☐ Sexual side effects |
| ☐ Headache | ☐ Confusion or memory problems |
| ☐ Rash, swelling, or allergic symptoms | ☐ Other: _____ |

Medication Management Follow-Up Questionnaire — continued

D. Symptom and function update

Item	0 None	1	2	3	4	5 Severe
Depression	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Irritability / anger	☐	☐	☐	☐	☐	☐
Mood elevation or racing thoughts	☐	☐	☐	☐	☐	☐
Attention / organization problems	☐	☐	☐	☐	☐	☐
Hallucinations, paranoia, or unusual beliefs	☐	☐	☐	☐	☐	☐
Sleep difficulty	☐	☐	☐	☐	☐	☐
Medication side effects	☐	☐	☐	☐	☐	☐
Overall interference with daily life	☐	☐	☐	☐	☐	☐

Average hours of sleep per night:

Current appetite / weight change:

Home blood pressure, if monitored:

Current pulse, if monitored:

Item	0 None	1	2	3	4	5 Severe
Current weight, if monitored:						
Last menstrual period, if applicable:						
Recent laboratory results available?						
Pharmacy changed?						

E. Safety and treatment priorities

Safety question	No	Yes	Unsure
Since your last visit, have you had thoughts of suicide, self-harm, or wishing you were dead?	☐	☐	☐
Since your last visit, have you had thoughts of harming someone else?	☐	☐	☐
Have hallucinations, beliefs, or impulses told you to do something dangerous?	☐	☐	☐
Do you feel able to stay safe today?	☐	☐	☐

What is the most important medication question or decision for today?

What medication benefit matters most to you before the next visit?
