THE PANS CENTER

Patient Intake Form
Medication History

Patient Name: ___________________________________ Date: _______________________

Completed by: ___________________________________

Current Prescription Medications, Supplements, Vitamins, and Minerals

Please list all **current** medications, supplements, vitamins and minerals, both prescribed and over the counter (psychiatric and non-psychiatric). Please add additional page(s) as necessary. We suggest that you ask your pharmacy for a print-out of your prescription history to support you in completing this.

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: ________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: _________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: _________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: _________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: _________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: _________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): ___________________ Strength: ______________
Quantity: ______ Frequency: _________________________ Started (Month/Year): ___________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency: ________________________ Started (Month/Year): __________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency: ________________________ Started (Month/Year): __________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency: ________________________ Started (Month/Year): __________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency: ________________________ Started (Month/Year): __________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency: ________________________ Started (Month/Year): __________________

Past Prescription, Supplements, Vitamins, and Minerals

Please list all **past** medications, supplements, vitamins and minerals, both prescribed and over the counter (psychiatric and non-psychiatric). Please add additional page(s) as necessary. We suggest that you ask your pharmacy for a print-out of your prescription history to support you in completing this.

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency:________________________ Started (Month/Year):___________________
Stopped (Month/Year): ________________ Reason Stopped: ___________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency:________________________ Started (Month/Year):___________________
Stopped (Month/Year): ________________ Reason Stopped: ___________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency:________________________ Started (Month/Year):___________________
Stopped (Month/Year): ________________ Reason Stopped: ___________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): __________________ Strength: _____________
Quantity: ______ Frequency:________________________ Started (Month/Year):___________________
Stopped (Month/Year): ________________ Reason Stopped: ___________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________

Medication Name: ____
Form (Tab/Cap/Liquid/Topical): _________________ Strength: ____________
Quantity: _____ Frequency:_______________________ Started (Month/Year):__________________
Stopped (Month/Year): _______________ Reason Stopped: _________________________________