**SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**

**MEDICATION REVIEW QUESTIONNAIRE**

**To be completed by CMH Staff: Case No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Do you think the medication prescribed for you is being helpful? **Yes ⁯ No ⁯**
2. In general, how have you been feeling since your last visit?  **Better ⁯Worse⁯ Unchanged⁯**
3. Are there any changes in your weight? **Increase ⁯ Decrease⁯ Unchanged⁯**
4. Are there any changes in your appetite? **Increase⁯ Decrease⁯ Unchanged⁯**
5. Are there any changes in your sleep pattern? **Yes ⁯ No ⁯**
6. Have you had any recent medical problems? **Yes ⁯ No ⁯**
7. Have you had any side effects from the medication prescribed here? **Yes ⁯ No ⁯**
8. Are you having any thoughts about harming yourself? **Yes ⁯ No ⁯**
9. Do you have questions about the medication prescribed here? **Yes ⁯ No ⁯**
10. Are you taking other prescribed medication(s)? **Yes ⁯ No ⁯**
11. Since your last visit, have you used any substances such as alcohol, marijuana, etc.?

**Yes ⁯ No ⁯**

Please add any other comments you have or problems you would like the doctor to address.

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Have you changed your address or phone number since your last visit? Yes\_\_\_ No\_\_\_

**Signature of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to individual receiving services: Self\_\_\_\_ Parent\_\_\_\_\_ Guardian\_\_\_\_\_\_ Home Provider/Staff\_\_\_\_\_\_\_**