Medication History

Please complete the following information regarding medications that you have tried in the past for treatment of depression, anxiety, mood swings, sleep problems or any other psychiatric symptom.

Medication	**Dates taken**	**Reason prescribed**	**Effect**	**Reason for stopping**
Example: Prozac	*1/05 – 9/05*	*Depression*	*Mild improvement of depression*	*Weight gain or stopped working*