Matthews-Vu
Healthcare for Children and Adults

# BH Medication Management Follow Up

Patient Name: _____ Date of Birth: _____ Date of Service: _____

**Goals for today's visit:**

For example refills, side effects, new problem _____
_____

**Health Update:**

Please describe your current mood: _____

Any new allergies, new medications or med adjustments, new pharmacies, medical problems, visits to the emergency room or hospitalization since last appointment? _____
_____
_____
Hours of sleep/night on average the last 2 weeks? _____
Sleepless nights since last appointment? Yes / No, how many? _____
Exercise routine: _____
Diet: Any soda or artificial sweeteners? _____ Vegan/Vegetarian, special diets? _____ Change in diet? _____

**Safety:**

Could you be pregnant? _____
Are you having thoughts about harming yourself or others? _____
Describe any excessive use of alcohol (over 2 drinks a day), use of drugs, cannabis products, energy drinks, or nicotine products? _____

**Stress:**

Any new stressors since last appointment? _____
Areas of high/increasing stress? _____
How are you coping with stress? E.g. counseling, friends/family, faith, fitness, creativity
_____
_____