**Medical History for Medication Management**

## NO MEDICATION RECONCILATION PRINTED NOTES WILL BE ACCEPTED

Patient Name: _____ DOB: _____ Phone:_____

Current Medical Diagnosis: _____

**Current Medications:**

| Medication | Dose |
|---|---|
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**Please indicate if the patient was treated or is currently being treated for:**

| Medical Comorbidities | Yes | No |
|---|---|---|
| Allergies/hay fever | | |
| Angina | | |
| Asthma/ COPD | | |
| Cardiac pacemaker | | |
| Intracardiac lines/Supplemental O2 | | |
| Diabetes | | |
| Epilepsy | | |
| Fainting spells or syncope | | |
| Head Trauma/concussion with or without LOC | | |
| Heart attacks | | |
| Kidney stones or other renal problems | | |
| Hemodynamic Instability | | |
| Intracranial HTN/Bleed | | |
| Hepatic Disorders | | |

| Medical Comorbidities | Yes | No |
|---|---|---|
| Hypertension | | |
| Metal Implants | | |
| Migraines | | |
| MRI in the past | | |
| Seizures | | |
| Strokes/TIAs | | |
| Syncope | | |
| Thyroid | | |
| Hypersensitivity to Ketamine/Esketamine/Excipients | | |
| IV Ketamine/Spravato in the past | | |
| TMS in the past | | |
| AV malformations | | |
| Intrathoracic/abdominal aneurysms | | |
| Other | | |

_____ _____

**Medical Provider Name and Office (printed)** **Signature**:

_____ _____ _____

**Date** **Phone** **Email**

Mood Institute
Advancing Psychiatry through Interventions

***Please send completed form records@depressionmd.com or our fax number is 877-325-2241***