Name____ Date______________

Current Medical Problems

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Past Medical Problems

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If possible, please bring (or have your doctor send to my office) records of your most recent physical exam and laboratory results. FAX:303-443-0845.

Please list all the psychiatric medications (anti-depressants, anti-anxiety, sleep, etc.) you have ever taken in the past, if any. Don't include your current medications.

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Please list all your current medications. (This includes all prescription medications taken for any reason, all naturopathic, homeopathic, or alternative medications, and any over-the-counter medications that you take frequently).

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