

Psychiatric Medication List

Cornerstone Psychiatric Services, Inc.

PATIENT INFORMATION

Patient Account#: _____

Last Name: _____

First Name: _____

Middle Name: _____

Suffix: JR SR III IV or _____

Nickname: _____

Date of Birth: ____/____/____

Common Psychiatric Medication List

Please indicate what psychiatric medications you've tried and anything you remember about its effect (helped, none, worse, etc.); side effects; the dose you recall taking; when and for how long you took it.

	Prescription Medication Name	Dose (How much) Mg, units, drops, etc.	Frequency (How often) 1 x day, 2x day, etc.	Date last taken	Effect and/or Side Effects Medication helped or worsened symptoms in what way?
Antidepressants	<input type="checkbox"/> Anafranil (clomipramine)				
	<input type="checkbox"/> Celexa (citalopram)				
	<input type="checkbox"/> Cymbalta (duloxetine)				
	<input type="checkbox"/> Effexor (venlafaxine)				
	<input type="checkbox"/> Elavil (amitriptyline)				
	<input type="checkbox"/> Fetzima (levomilnacipram)				
	<input type="checkbox"/> Lexapro (escitalopram)				
	<input type="checkbox"/> Luvox (fluvoxamine)				
	<input type="checkbox"/> Palelor (nortriptyline)				
	<input type="checkbox"/> Paxil (paroxetine)				
	<input type="checkbox"/> Pexeva (paroxetine mesylate)				
	<input type="checkbox"/> Pristiq (desvenlafaxine)				
	<input type="checkbox"/> Prozac (fluoxetine)				
	<input type="checkbox"/> Remeron (mirtazapine)				
	<input type="checkbox"/> Sinequan (doxepin)				
	<input type="checkbox"/> Tofranil (imipramine)				
	<input type="checkbox"/> Trintellix (vortioxetine)				
	<input type="checkbox"/> Viibryd (vilazodone)				
	<input type="checkbox"/> Wellbutrin (bupropion)				
<input type="checkbox"/> Zoloft (sertraline)					
<input type="checkbox"/> Other:					

	Prescription Medication Name	Dose (How much) Mg, units, drops, etc.	Frequency (How often) 1 x day, 2x day, etc.	Date last taken	Effect and/or Side Effects Medication helped or worsened symptoms in what way?
Mood Stabilizers	<input type="checkbox"/> Depakote (valproate)				
	<input type="checkbox"/> Lamictal (lamotrigine)				
	<input type="checkbox"/> Tegretol (carbamazepine)				
	<input type="checkbox"/> Trileptal (oxcarbazepine)				
	<input type="checkbox"/> Other:				

	Prescription Medication Name	Dose (How much) Mg, units, drops, etc.	Frequency (How often) 1 x day, 2x day, etc.	Date last taken	Effect and/or Side Effects Medication helped or worsened symptoms in what way?
Atypical Antipsychotics / Mood Stabilizers	<input type="checkbox"/> Abilify (aripiprazole)				
	<input type="checkbox"/> Clozaril (clozapine)				
	<input type="checkbox"/> Geodon (ziprasidone)				
	<input type="checkbox"/> Haldol (haloperidol)				
	<input type="checkbox"/> Latuda (lurasidone)				
	<input type="checkbox"/> Prolixin (fluphenazine)				
	<input type="checkbox"/> Risperdal (risperdone)				
	<input type="checkbox"/> Seroquel (quetiapine)				
	<input type="checkbox"/> Seroquel XR (quetiapine xr)				
	<input type="checkbox"/> Vraylar (cariprazine)				
	<input type="checkbox"/> Zyprexa (olanzapine)				
	<input type="checkbox"/> Other:				

Typical Antipsychotics	<input type="checkbox"/> Haldol (haloperidol)				
	<input type="checkbox"/> Thorazine (chlorpromazine)				
	<input type="checkbox"/> Other:				

Anti-Anxiety	<input type="checkbox"/> Ativan (lorazepam)				
	<input type="checkbox"/> Buspar (buspirone)				
	<input type="checkbox"/> Chlordiazepoxide				
	<input type="checkbox"/> Klonopin (clonazepam)				
	<input type="checkbox"/> Tranxene (clorazepate)				
	<input type="checkbox"/> Valium (diazepam)				
	<input type="checkbox"/> Vistaril (hydroxyzine)				
	<input type="checkbox"/> Xanax (alprazolam)				
<input type="checkbox"/> Other:					

Typical Antipsychotics	<input type="checkbox"/> Haldol (haloperidol)				
	<input type="checkbox"/> Thorazine (chlorpromazine)				
	<input type="checkbox"/> Other:				

Patient Account#: _____

	Prescription Medication Name	Dose (How much) Mg, units, drops, etc.	Frequency (How often) 1 x day, 2x day, etc.	Date last taken	Effect and/or Side Effects Medication helped or worsened symptoms in what way?
Sedatives / Sleep Aides	<input type="checkbox"/> Ambien (zolpidem)				
	<input type="checkbox"/> Ambien CR (zolpidem cr)				
	<input type="checkbox"/> Belsomra (suvorexant)				
	<input type="checkbox"/> Desyrel (trazadone)				
	<input type="checkbox"/> Restoril (temazepam)				
	<input type="checkbox"/> Rozerem (ramelteon)				
	<input type="checkbox"/> Sonata (zaleplon)				
	<input type="checkbox"/> Other:				

ADHD	<input type="checkbox"/> Adderall (amphetamine)				
	<input type="checkbox"/> Adderall XR				
	<input type="checkbox"/> Concerta (methylphenidate)				
	<input type="checkbox"/> Daytrana (methylphenidate)				
	<input type="checkbox"/> Dyanavel XR				
	<input type="checkbox"/> Eveko				
	<input type="checkbox"/> Focalin (dexmethylphenidate)				
	<input type="checkbox"/> Metadate (methylphenidate)				
	<input type="checkbox"/> Mydayis				
	<input type="checkbox"/> Quillivant XR				
	<input type="checkbox"/> Ritalin (methylphenidate)				
	<input type="checkbox"/> Strattera (atomoxetine)				
	<input type="checkbox"/> Vyvanse (lisdexamfetamine)				
	<input type="checkbox"/> Other:				

Other	<input type="checkbox"/> Deplin (l-methylfolate)				
	<input type="checkbox"/> CerefolinNAC				
	<input type="checkbox"/> EnLyte w/DeltaFolate				
	<input type="checkbox"/> Exelon Patch				
	<input type="checkbox"/> Lithium				
	<input type="checkbox"/> Namzaric				
	<input type="checkbox"/> Neurontin (gabapentin)				
	<input type="checkbox"/> Topamax (topiramate)				
	<input type="checkbox"/> Other:				

Patient Account#: _____

X _____
Signature of Patient, Parent, Guardian or Personal Representative

List Completed on Date