Aviation Medicine Center

Depression

Patient Information				
Patient's Name				/ /
	First	**Last**	**Middle**	**Date of Birth**

Medication List

	Medication	Dosage	Frequency	Date Medication Started	Last Day of Medication Usage
1.				/ /	/ /
2.				/ /	/ /
3.				/ /	/ /
4.				/ /	/ /

Patient History

	YES	NO	NA
Did the patient develop any side effects to the medication(s)?	❑	❑	❑
Does the patient have a history of bipolar disorder?	❑	❑	❑
Does the patient have a personality disorder?	❑	❑	❑
Does the patient have a history of psychosis?	❑	❑	❑
Does the patient have a history of substance abuse (alcohol and or drugs)?	❑	❑	❑
Does the patient have a history of substance dependence?	❑	❑	❑
Does the patient have a history of suicide attempt?	❑	❑	❑
Does the patient have a history of using psychotropic medications for smoking cessation	❑	❑	❑
Is there any history of an attention deficient or hyperactivity disorder?	❑	❑	❑
Was the patient treated for less than six (6) months on antidepressant medication?	❑	❑	❑

Diagnosis

	YES	NO	NA
Was the patient's diagnosis an adjustment disorder?	❑	❑	❑
Was the patient's diagnosis due to bereavement?	❑	❑	❑
Was the patient's diagnosis due to minor depression?	❑	❑	❑

Update

	YES	NO	NA
Have there been any recurrent episodes of depression since stopping medication?	❑	❑	❑
In your opinion is the patient stable since stopping antidepressant medication?	❑	❑	❑
In your opinion is the patient's depression resolved?	❑	❑	❑
	❑	❑	❑

Physician Name	Physician Phone Number	Physician Signature	Date
			/ /

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