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NEUROTRANSMITTER ASSESSMENT FORM™ (NTAF)

Name: _____ Date of Birth: _____ Sex: Male Female Date: _____
 Address: _____ Email: _____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A	0	1	2	3
Is your memory noticeably declining?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you having a hard time remembering names and phone numbers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your ability to focus noticeably declining?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has it become harder for you to learn new things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a hard time remembering your appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your temperament generally getting worse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your attention span decreasing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you find yourself down or sad?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you become fatigued when driving compared to in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you become fatigued when reading compared to in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you walk into rooms and forget why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you pick up your cell phone and forget why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SECTION B	0	1	2	3
How high is your stress level?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel you have something that must be done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you never have time for yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel you are not getting enough sleep or rest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to get regular exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel uncared for by the people in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel you are not accomplishing your life's purpose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is sharing your problems with someone difficult for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SECTION C1	0	1	2	3
How often do you get irritable, shaky, or have light-headedness between meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel energized after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty eating large meals in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often does your energy level drop in the afternoon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you crave sugar and sweets in the afternoon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you wake up in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty concentrating before eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you depend on coffee to keep yourself going?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel agitated, easily upset, and nervous between meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C2	0	1	2	3
How often do you get fatigued after meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you crave sugar and sweets after meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel you need stimulants, such as coffee, after meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty losing weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much larger is your waist girth compared to your hip girth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have your thirst and appetite increased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you gain weight when under stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SECTION 1	0	1	2	3
Are you losing interest in hobbies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel overwhelmed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of inner rage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of paranoia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel sad or down for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel like you are not enjoying life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel you lack artistic appreciation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel depressed in overcast weather?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much are you losing your enthusiasm for your favorite activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much are you losing your enjoyment for your favorite foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much are you losing your enjoyment of friendships and relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty falling into deep, restful sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of dependency on others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel more susceptible to pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of unprovoked anger?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much are you losing interest in life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 2**0 1 2 3**

How often do you have feelings of hopelessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have self-destructive thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have an inability to handle stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have anger and aggression while under stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel you are not rested, even after long hours of sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you prefer to isolate yourself from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have unexplained lack of concern for family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How easily are you distracted from your tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have an inability to finish tasks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel the need to consume caffeine to stay alert?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel your libido has been decreased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you lose your temper for minor reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of worthlessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 3**0 1 2 3**

How often do you feel anxious or panicked for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of dread or impending doom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel knots in your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of being overwhelmed for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of guilt about everyday decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often does your mind feel restless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How difficult is it to turn your mind off when you want to relax?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have disorganized attention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you worry about things you were not worried about before?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have feelings of inner tension and inner excitability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4**0 1 2 3**

Do you feel your visual memory (shapes & images) has decreased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your verbal memory has decreased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have memory lapses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your creativity decreased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your comprehension diminished?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty calculating numbers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty recognizing objects & faces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel like your opinion about yourself has changed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing excessive urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you experiencing a slower mental response?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 5**0 1 2 3**

A decrease in mental alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A decrease in mental speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A decrease in concentration quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow cognitive processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired mental performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
An increase in the ability to be distracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need coffee or caffeine sources to improve mental function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION HISTORY*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Remeron® | <input type="checkbox"/> Norset® |
| <input type="checkbox"/> Zispin® | <input type="checkbox"/> Remergil® |
| <input type="checkbox"/> Avanza® | <input type="checkbox"/> Axit® |

Tricyclic Antidepressants (TCAs)

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Elavil® | <input type="checkbox"/> Prothiaden® |
| <input type="checkbox"/> Endep® | <input type="checkbox"/> Adapin® |
| <input type="checkbox"/> Tryptanol® | <input type="checkbox"/> Sinequan® |
| <input type="checkbox"/> Trepiline® | <input type="checkbox"/> Tofranil® |
| <input type="checkbox"/> Asendin® | <input type="checkbox"/> Janamine® |
| <input type="checkbox"/> Asendis® | <input type="checkbox"/> Gamamil® |
| <input type="checkbox"/> Defanyl® | <input type="checkbox"/> Aventyl® |
| <input type="checkbox"/> Demolox® | <input type="checkbox"/> Pamelor® |
| <input type="checkbox"/> Moxadil® | <input type="checkbox"/> Opipramol® |
| <input type="checkbox"/> Anafranil® | <input type="checkbox"/> Vivactil® |
| <input type="checkbox"/> Norpramin® | <input type="checkbox"/> Rhotrimine® |
| <input type="checkbox"/> Pertofrane® | <input type="checkbox"/> Surmontil® |
| <input type="checkbox"/> Thaden™ | <input type="checkbox"/> Norpramin® |

Selective Serotonin Reuptake Inhibitors (SSRIs)

- | | |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Paxil® | <input type="checkbox"/> Seromex® |
| <input type="checkbox"/> Zoloft® | <input type="checkbox"/> Seronil® |
| <input type="checkbox"/> Prozac® | <input type="checkbox"/> Sarafem® |
| <input type="checkbox"/> Celexa® | <input type="checkbox"/> Fluctin® |
| <input type="checkbox"/> Lexapro® | <input type="checkbox"/> Faverin® |
| <input type="checkbox"/> Esertia® | <input type="checkbox"/> Seroxat® |
| <input type="checkbox"/> Luvox® | <input type="checkbox"/> Aropax® |
| <input type="checkbox"/> Cipramil® | <input type="checkbox"/> Deroxat® |
| <input type="checkbox"/> Emocal® | <input type="checkbox"/> Rexetin® |
| <input type="checkbox"/> Seropram® | <input type="checkbox"/> Paroxat® |
| <input type="checkbox"/> Ciprallex® | <input type="checkbox"/> Lustral® |
| <input type="checkbox"/> Fontex® | <input type="checkbox"/> Serlain® |
| <input type="checkbox"/> Priligy® | |

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Effexor® | <input type="checkbox"/> Pristiq® |
| <input type="checkbox"/> Meridia® | <input type="checkbox"/> Serzone® |
| <input type="checkbox"/> Dalcipran® | <input type="checkbox"/> Cymbalta® |

Selective Serotonin Reuptake Enhancers (SSREs)

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Stablon® | <input type="checkbox"/> Coaxil® |
| <input type="checkbox"/> Tatinol® | |

Monoamine Oxidase Inhibitors (MAOIs)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Marplan® | <input type="checkbox"/> Marsilid® |
| <input type="checkbox"/> Aurorix® | <input type="checkbox"/> Iprozid® |
| <input type="checkbox"/> Manerix® | <input type="checkbox"/> Ipronid® |
| <input type="checkbox"/> Moclodura® | <input type="checkbox"/> Rivivol® |
| <input type="checkbox"/> Nardil® | <input type="checkbox"/> Propilniazida® |
| <input type="checkbox"/> Adeline® | <input type="checkbox"/> Zyvox® |
| <input type="checkbox"/> Eldepryl® | <input type="checkbox"/> Zyvoxid® |
| <input type="checkbox"/> Azilect® | |

Dopamine Receptor Agonists

- | | |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Mirapex® | <input type="checkbox"/> Sifrol® |
| <input type="checkbox"/> Requip® | |

Norepinephrine-Dopamine Reuptake Inhibitors (NDRIs)

- | |
|---|
| <input type="checkbox"/> Wellbutrin XL® |
|---|

D2 Dopamine Receptor Blockers (antipsychotics)

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Thorazine® | <input type="checkbox"/> Acuphase® |
| <input type="checkbox"/> Prolixin® | <input type="checkbox"/> Haldol® |
| <input type="checkbox"/> Trilafon® | <input type="checkbox"/> Orap® |
| <input type="checkbox"/> Compazine® | <input type="checkbox"/> Clozaril® |
| <input type="checkbox"/> Mellaril® | <input type="checkbox"/> Zyprexa® |
| <input type="checkbox"/> Stelazine® | <input type="checkbox"/> Zydis® |
| <input type="checkbox"/> Vesprin® | <input type="checkbox"/> Seroquel XR® |
| <input type="checkbox"/> Nozinan® | <input type="checkbox"/> Geodon® |
| <input type="checkbox"/> Depixol® | <input type="checkbox"/> Solian® |
| <input type="checkbox"/> Navane® | <input type="checkbox"/> Invega® |
| <input type="checkbox"/> Fluaxol® | <input type="checkbox"/> Abilify® |
| <input type="checkbox"/> Clopixol® | |

GABA Antagonist Competitive Binder

- | |
|-------------------------------------|
| <input type="checkbox"/> Romazicon® |
|-------------------------------------|

Agonist Modulators of GABA Receptors (benzodiazepines)

- | | |
|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Xanax® | <input type="checkbox"/> Dalmane® |
| <input type="checkbox"/> Lexotanil® | <input type="checkbox"/> Ativan® |
| <input type="checkbox"/> Lexotan® | <input type="checkbox"/> Loramet® |
| <input type="checkbox"/> Librium® | <input type="checkbox"/> Sedoxil® |
| <input type="checkbox"/> Klonopin® | <input type="checkbox"/> Dormicum® |
| <input type="checkbox"/> Valium® | <input type="checkbox"/> Serax® |
| <input type="checkbox"/> Prosom® | <input type="checkbox"/> Restoril® |
| <input type="checkbox"/> Rohypnol® | <input type="checkbox"/> Halcion® |
| <input type="checkbox"/> Magadon® | |

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- | | |
|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ambien CR® | <input type="checkbox"/> Sonata® |
| <input type="checkbox"/> Lunesta® | <input type="checkbox"/> Imovane® |

Acetylcholine Receptor Agonists

- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Urecholine® | <input type="checkbox"/> Isopto® |
| <input type="checkbox"/> Evoxac® | <input type="checkbox"/> Nicotone |
| <input type="checkbox"/> Salagen® | |

Acetylcholine Receptor Antagonists (antimuscarinic agents)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> AtroPen® | <input type="checkbox"/> Atrovent® |
| <input type="checkbox"/> Scopace® | <input type="checkbox"/> Spiriva® |

Acetylcholine Receptor Antagonists (ganglionic blockers)

- | | |
|--|--|
| <input type="checkbox"/> Inversine® | <input type="checkbox"/> Hexamethonium |
| <input type="checkbox"/> Nicotine (high doses) | <input type="checkbox"/> Arfonad® |

Acetylcholine Receptor Antagonists (neuromuscular blockers)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Tracrium® | <input type="checkbox"/> Zemuron® |
| <input type="checkbox"/> Nimbex® | <input type="checkbox"/> Anectine® |
| <input type="checkbox"/> Nuromax® | <input type="checkbox"/> Tubocurarine® |
| <input type="checkbox"/> Metubine® | <input type="checkbox"/> Norcuron® |
| <input type="checkbox"/> Mivacron® | <input type="checkbox"/> Hemicholinium-3® |
| <input type="checkbox"/> Pavulon® | |

Acetylcholinesterase Reactivators

- | |
|------------------------------------|
| <input type="checkbox"/> Protopam® |
|------------------------------------|

Cholinesterase Inhibitors (reversible)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Aricept® | <input type="checkbox"/> Enlon® |
| <input type="checkbox"/> Razadyne® | <input type="checkbox"/> Prostigmin® |
| <input type="checkbox"/> Exelon® | <input type="checkbox"/> Antilirium® |
| <input type="checkbox"/> Cognex® | <input type="checkbox"/> Mestinon® |
| <input type="checkbox"/> THC | <input type="checkbox"/> Carbamate insecticides |

Cholinesterase Inhibitors (irreversible)

- | |
|--|
| <input type="checkbox"/> Echothiophate |
| <input type="checkbox"/> Isoflurophate |
| <input type="checkbox"/> Organophosphate insecticides |
| <input type="checkbox"/> Organophosphate-containing nerve agents |