Glasgow Antipsychotic Side-effect Scale (GASS) for Clozapine

Name:	**Age:**	**Male:** **Female:**	**Date:**
How many cups of coffee or tea you drink each day............ **How much fizzy juice or energy drinks............**			
Do you Smoke: If Yes how many cigarettes a day........ **No.......** **Has there been a recent change in your smoking habit?** **Are you smoking? More+………Less- ……. cigarettes/day**			

This is to find out how you have been recently while taking this medicine. It is to find out if you have had any side effects from your medication.

Please place a tick ✔ in the column if you have experienced any of the following side effects.

Tick ✔ the **end** box if you found that the side effects upset you.

	Over the **past week:**	Never	Once	A few times	Every day	Tick this box if it upsets you
	I felt sleepy during the day					
	I felt drugged or like a zombie					
	I felt dizzy when I stood up and/or have fainted					

	Over the **past week:**	Never	Once	A few times	Every day	Tick this box if it upsets you
	I have felt my heart beating faster					
	My muscles have been tense or jerky					
	I have been drooling					
	My vision has been blurry					
	My mouth has been dry					
	I have felt sick or have vomited					

	Over the **past week:**	Never	Once	A few times	Every day	Tick this box if it upsets you
	I have felt **heartburn** or gastric reflux					
	I have problems going to the toilet					
	I have wet the bed					
	I have been passing urine more often					
	I have been thirsty					
	I have felt more hungry					

	Over the **past week:**	Never	Once	A few times	Every day	Tick this box if it upsets you
	I have been gaining weight					
	I have felt breathless					
	I have had chest pain					

Have you had any other side effects over the last week:

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