




Glasgow Antipsychotic Side-effect Scale (GASS)

Name:	Age:	Male: Female:	Date:
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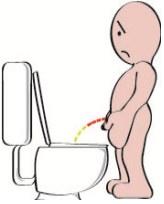
This is to find out how you have been recently. It is to find out if you have had any side effects from your medication.

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					
	My hands or arms have been shaky					
	My legs have felt restless and/or I couldn't sit still					
	I have been drooling					

	Over the past week :	Never	Once	A few times	Every day	Tick this box if it upsets you
	My movements or walking have been slower					
	I have had, or people have noticed movements of my face or body					
	My vision has been blurry					
	My mouth has been dry					
	I have had difficulty passing urine					

	Over the past week :	Never	Once	A few times	Every day	Tick this box if it upsets you
	I have felt sick or have vomited					
	I have wet the bed					
	I have been very thirsty and/or passing urine frequently					
	The areas around my nipples have been sore and swollen					
	I have noticed fluid coming from my nipples					

	Over the past week:	Never	Once	A few times	Every day	Tick this box if it upsets you
	I have had problems enjoying sex					
	Men only: I have had problems getting an erection					

Tick yes or no for the following questions about the **last three months**

	No	Yes	Tick if distressing
