GASE-D: Generic Assessment of Side Effects
Doctors´ Version

Please rate the intensity of the following complaints reported by your patient for the last seven days by using the scale below. Please indicate by circling yes or no whether you believe that these symptoms are related to patient's current medication**.**

= not assessed / not to determine

0 = Complaint not present
1 = Mild: complaint causes mild distress or discomfort, but no impairment in daily functioning
2 = Moderate: complaint causes moderate distress or discomfort or at least some impairment in daily functioning
3 = Severe: complaint causes severe distress and discomfort, severe impairment in daily functioning, or acute danger to health

Please try to choose an answer even when you are not completely sure if the complaint is related to the prescribed medication!

In the last seven days my patient had the following complaints:

Complaints	**Intensity** unratable not present – mild – moderate - severe	Is this complaint related to patient's current medication?
Headache	0-------1-------2-------3	O yes O no
Loss of hair	0-------1-------2-------3	O yes O no
Dry mouth	0-------1-------2-------3	O yes O no
Dizziness	0-------1-------2-------3	O yes O no
Chest Pain	0-------1-------2-------3	O yes O no
Tachycardia, Palpitation or arrhythmia	0-------1-------2-------3	O yes O no
Breathing problems	0-------1-------2-------3	O yes O no
Low blood pressure, other circulatory problems	0-------1-------2-------3	O yes O no
Abdominal pain	0-------1-------2-------3	O yes O no
Nausea	0-------1-------2-------3	O yes O no
Vomiting	0-------1-------2-------3	O yes O no
Constipation	0-------1-------2-------3	O yes O no
Diarrhea	0-------1-------2-------3	O yes O no
Reduced appetite	0-------1-------2-------3	O yes O no
Increased appetite	0-------1-------2-------3	O yes O no
Difficulties with urination	0-------1-------2-------3	O yes O no
Problems with sexuality or genitals	0-------1-------2-------3	O yes O no
Females: Painful or irregular menstruation	0-------1-------2-------3	O yes O no
Skin Rash or Itching	0-------1-------2-------3	O yes O no
Tendency to develop bruises	0-------1-------2-------3	O yes O no

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Fever,	0-------1-------2-------3	O yes O no
sweating	0-------1-------2-------3	O yes O no
Hot Flushes	0-------1-------2-------3	O yes O no
Convulsions	0-------1-------2-------3	O yes O no
Fatigue, loss of energy	0-------1-------2-------3	O yes O no
Tremor	0-------1-------2-------3	O yes O no
Insomnia, sleeping problems	0-------1-------2-------3	O yes O no
Nightmares or abnormal dreams	0-------1-------2-------3	O yes O no
Back pain	0-------1-------2-------3	O yes O no
Muscle pain	0-------1-------2-------3	O yes O no
Joint pain		O yes O no
	0-------1-------2-------3	
Agitation	0-------1-------2-------3	O yes O no
Irritability	0-------1-------2-------3	O yes O no
Depressed mood	0-------1-------2-------3	O yes O no
Thoughts about suicide	0-------1-------2-------3	O yes O no
Anxiety, Fearfulness	0-------1-------2-------3	O yes O no
Further symptoms: (please name these symptoms:)	0-------1-------2-------3 0-------1-------2-------3 0-------1-------2-------3	O yes O no O yes O no O yes O no

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